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Educating the Public in Health*

By W. W. BAUER, B.S., M.D.

LET us begin by acknowledging that the word education is probably the most abused, or at least the most carelessly employed word in the vocabulary of professional people, to say nothing of many who pretend to be professional. Every wily quack, every half-baked faker, every misguided cultist, announces by radio, in personal appearance, and through the printed word that he is educating the public in health. So does the commercial advertiser, including the one with something of real merit to sell and the one who is merely cashing in on the popular interest in health. It is no wonder that the voice of the genuine health educator is frequently lost in the babel of tongues.

We must make another acknowledgment and that is that most of us engaged in health instruction are self-designated health educators. The ideal health educator is one who has a knowledge of medicine and its allied sciences, plus training and experience in teaching. Individuals possessing such qualifications are rare. Consequently it has become necessary for many, like myself, to do the best they can without the ideal qualifications, but with at least a sincere desire to lead the people aright when it comes to matters of health. It is not, therefore, necessarily a reproach to say that health educators are self-designated. The field was fallow; it cried for cultivation; those who saw the need had perforce to meet it as best they could.

There are four major questions which must be answered in order to approach intelligently the subject of public instruction in health. These questions were formulated by the recent Health Education Institute held by the American Public Health Association in connection with its sixty-first annual meeting at Washington, D. C. They are as follows:

1. How does one go about determining the special items of a health education program?
2. How does one decide what audiences one should reach?

*Read at the Conference of Public Health Officers and Nurses, Springfield, Illinois, December 16, 1932.

3. Where does one secure the most authoritative facts to present to one's audiences?
4. How does one decide what instruments are best suited for the execution of the program?

Such questions cannot be answered fully in this paper, but they are worth thinking about, because they enable each of us to visualize our problem as a whole and then to attack it in a logical, consecutive fashion instead of nibbling at it here and there when we are not busy with something else. In other words, we must have a program, not merely a hit-or-miss activity.

BASIS OF SELECTING ITEMS ON PROGRAM

Considering the first question, it is worth while to remind you that the *basis* on which one selects the special items for a health education program must be decided first, no matter whether we happen to be connected with a city or state department of health, a local or national voluntary organization, a medical society, or one of the groups with restricted interests, like tuberculosis, heart disease, and cancer. Whatever may be our specific interest, and wherever we may be working, we must procure the answer to this question from certain sources, briefly outlined here:

A study must be made of the mortality statistics and, in so far as they are available, the morbidity statistics as a whole, or of those pertaining to one or more groups of diseases or conditions with which the health educator is concerned. For example, if the program is to be planned for a health department, then it must first be decided whether health education is to emphasize communicable disease control, a sanitary problem such as sewerage, water or milk supply, or the diseases of adult and middle life. A health educator working in an anti-tuberculosis movement will, obviously, deal with tuberculosis, but even so, must decide to emphasize certain phases, such as reporting of cases, sanatorium care, childhood tuberculosis, or perhaps home care. The circumstances in the community will reveal what constitutes the most important problem.

Second, having ascertained where the greatest need exists, it will be necessary to review what opportunities exist in the community to fill the need. No localities are able to meet all their health problems; few are able to meet even all of those for which medical and sanitary science have made a remedy available. The health educator must ascertain what opportunities exist for improving the situation. For example, in a community with no available sanatorium and a high tuberculosis incidence, it is obviously futile to put on an educational campaign for hospitalization; but it may be highly desirable to awaken the community to the need for providing sanatorium facilities. Even narrowing it down to the question of providing sanatorium facilities, the decision still remains to be made whether to advocate a program of construction, contracts with nearby sanatoria, or arrangements with existing private institutions.

The statistical data cannot always be taken as a sole guide. For example, in the average community, the causes of death in the order of their greatest prevalence (assuming that pneumonia is not above the average) are likely to run in the following order: heart disease, cancer, apoplexy or kidney disease, tuberculosis or pneumonia. Apoplexy and kidney disease may alternate. If pneumonia or influenza are unduly prevalent they may be found higher in the list with others correspondingly displaced downward. It does not follow that the first health effort in the community or the major health effort shall be directed at heart disease merely because it is first in the list. Further study will probably disclose the fact that a large percentage of the deaths from heart disease are in older age groups and that to a considerable extent the presence of heart disease at the head of the list may be interpreted as a favorable factor in the community's health. Moreover, only a compara-

tively small percentage of heart disease deaths is susceptible to prevention.

On the other hand, diphtheria and smallpox may be comparatively low in the mortality statistics, while ranking high in morbidity. These diseases are readily attacked and prevented and hence they should be made the subject of more attention than heart disease. A still further consideration is that reduction of the acute communicable diseases may be expected to have a secondary, favorable influence upon heart disease, though this will not be manifest for a considerable number of years. In other words, the health educator must make a practical approach and, like the astute military commander, must avoid dashing his strength and decimating his forces against impregnable positions of the enemy. He must strike not only where the need is great, but where results can be realized, in order that he may not be guilty of wasting time, effort, and money.

In addition to getting definite results from his endeavors, he must bear in mind some secondary but not less important objectives, such as obtaining and maintaining support for existing health activities which have shown results commensurate with their cost and of proposed activities which give reasonably satisfactory indication of valuable results at a cost which the community can bear. He must also keep in mind the objective of persuading the individual to abandon unhygienic practices and to adopt at least an approximation of specific health habits which have been demonstrated to be sound.

THE AUDIENCE

Having thus surveyed the field of battle, estimated the strength of opposition in comparison with the weapons at hand for overcoming it, the health educator proceeds next to a definite plan of attack. He chooses the audience to whom the program of health education is to be addressed. In this connection may I tell an experience of my own? I was reading a book of epitaphs one evening and I came to one which told about the death of four persons in one family back in the sixteenth century under circumstances which seemed to fit perfectly our modern knowledge of tuberculosis. The fanciful description in the epitaph pointed out that in each death there was present in the room a bird with a white breast fluttering about the patient's bed. I seized upon this and made it the basis of a circular on tuberculosis for local distribution. Later I showed it to an experienced health educator, executive of a successful state tuberculosis association. He looked it over, laid it upon his desk, disarmed me with a smile, and then tore my masterpiece apart with these words:

"This is a literary gem, but an educational dud."

I had failed to choose my audience. I had not realized that a large majority of those whom I hoped to impress with this effort did not understand the sixteenth century, would not see the same significance in the fanciful epitaph that I saw, and, finally, would not apply the lesson to tuberculosis in our own day. I do not mean that the sixteenth century cannot be interpreted to certain audiences of today; I do not mean that the imagery of such an epitaph cannot be utilized; and I do not mean that the application cannot be made to our present-day situation. I mean to imply simply that I had failed because I had not chosen my audience wisely. To an historical society, or a literary guild, or an audience of college people my approach would have been excellent. To the wage-earners and housewives of an industrial community, where the average education did not go much beyond the eighth grade, I had shot over their heads.

Let me cite by contrast an example of a better piece of publicity. A certain health department was planning a smallpox and vaccination drive in April. Gas bills are distributed in that community in three districts on the 1st, 10th and 20th of the month, respectively. The health officer started his vaccination work in those districts just a few days after the distribution of the gas

bills, after procuring the consent of the gas company to distribute with each bill an appeal for vaccination. This appeal was then printed on cheap but striking green paper, in green ink, with the bold type head, "This Is No April Fool." It went into every home, just before the work in that particular district began. The time was propitious. The blind title made people read further. The rest of the message, because space was limited, was brief and to the point. People read it. Moreover, they went and were vaccinated. The cost of fifteen thousand such appeals was less than the cost of eight thousand of the tuberculosis folder. You have here contrasting examples of how to choose and how not to choose an audience. In other words, indiscriminate propagandizing is likely to prove wasteful. Audiences must be selected on the basis of their fundamental interest, their capacity to understand, and their ability to act upon the information and the motivation presented.

To go into a little more detail, the subject of periodic health examinations is, or should be, of universal interest and so is the question of pure milk. On the other hand, diphtheria prevention would be of interest primarily to parents of young children and maternity hygiene to the younger group of married women. There are, of course, exceptions as, for example, maternity hygiene may be of interest also to older women whose daughters are in the child-bearing age. Of course, all health matters are of interest to physicians, nurses, social workers, and teachers. It would be well worth while to take time to divide the community into various groups and opposite each to note what special interests each of them might have in connection with health education. Such a list may be based on the following grouping which must, obviously, be modified to suit each individual community:

1. Official groups, representing the community government. These include executive, legislative, educational, and judicial.
2. Professional groups, such as doctors, nurses, lawyers, and clergy.
3. Voluntary health organizations.
4. Social service groups, including family welfare, recreation, and character-building agencies.
5. The press, including daily or weekly, American or foreign language.
6. Business leaders, mercantile and industrial, as represented through the Chamber of Commerce and allied groups.
7. Parent-Teacher Associations and community club groups.
8. Women's clubs and women's study groups.
9. Industrial or clerical workers.
10. Boys' groups, such as Scouts, Y.M.C.A., camps and clubs.
11. Girls' groups, including Scouts, Campfire Girls, Y.W.C.A., and clubs.
12. Specialized trades affecting the public health, such as barbers, beauty operators, food handlers, undertakers, and pharmacists.
13. Men's luncheon clubs.
14. Fraternal and mutual benefit groups.
15. Theatrical interests.
16. Churches and religious organizations.
17. All groups not previously named, such as patriotic organizations and miscellaneous clubs and other groups.

WHERE TO GET MATERIAL

Having decided what subjects to present and having selected the groups to whom they are to be presented, the next question arises—how and where can good authentic material be secured? This question is not always answered as readily as should be the case. Official health agencies as a rule put out dependable material. Textbooks, carefully chosen on the basis of reviews by medical journals, are a good source. The large national voluntary health organizations will furnish authentic material, if one bears in mind that each of them has a definite end to serve and therefore emphasizes its own viewpoint. If every health educator or health executive were to do all the things that are advocated by any one of the special societies, he would have to devote his whole time to that alone and his program would be lopsided.

It is necessary to gather material from all sources and then to choose carefully. If the health educator is not a physician, then physicians should censor everything that is used. It is wise to have the local medical society

appoint a committee to whom all health educational material to be used in the community shall be submitted before release. This is a great protection to the public and to the persons responsible for health education, since it prevents errors and unwise or ambiguous statements and makes for consistency. If the local medical society committee is not available, then the alternative would be the nearest available medical authority, such as a medical school, state health department, or health specialists such as statisticians, nutritionists, bacteriologists, or engineers. Obviously specialists can be of service only in the field of their special interest.

WHAT OF COMMERCIAL MATERIAL?

It is necessary to say a word about commercial health material. There is a vast amount of this, some of it good, some mediocre, and some definitely bad. The mere fact that a project is commercial should not of itself condemn its publications and yet there may be questions of policy involved in undertaking to distribute even the best of commercial health education material. Since the underlying motive of commercial health education projects is the financial welfare of the sponsor—and this does not imply that he lacks public-spirited interest in the welfare of his clients—there may be objections to utilizing even the good material which emanates from commercial sources. On the other hand, if after careful consideration the utilization of available material high in quality, derived from commercial sources, does not raise questions of policy, then it should be accepted or rejected on its merits and its commercial origin ignored. The test, of course, is whether the information given is correct. For example, if those interested in the sale of any given commodity or service, endeavor to stimulate such sale by setting forth in a proper manner the scientific, authenticated facts concerning their product in its relation to health, they are distinctly within their rights. Whether or not you, as official, semi-official, or voluntary health educators, wish to use their material must be determined in the light of all the circumstances.

HEALTH EDUCATION INSTRUMENTS

Having now answered in general terms the first three fundamental questions, we ask ourselves the fourth—what health education instruments should be used? Naturally, the choice of instruments depends upon the content of our material, audiences to be reached, budget, personnel, and physical conditions in the community. We must weigh carefully such items of primary significance as the degree of literateness, language use, cultural and economic level of one's audience. For example, a cosmopolitan center might justify and indeed demand the printing of health literature in as many as a dozen languages, while in most communities English alone would serve. In occasional circumstances it may be necessary to use a language which would be entirely wasteful somewhere else as, for example, a certain city with a considerable Armenian population where the health officer had a diphtheria prevention appeal translated by a missionary into modern Turkish and got results that justified the expenditure. Further, we would not waste time or money on a radio program in a community where few receiving sets were operated, nor would we put on a health talk in Polish in a community consisting largely of Germans and Irish. I have perhaps exaggerated, but I have done so with malicious intent to emphasize that there have been health education efforts, so-called, which were no less futile than talking health in Polish to a group of Greek immigrants.

THE RADIO

Let us look briefly at some of the more important media through which we may present our message to our people. First, because it is newest and therefore most interesting, the radio. Every health educator should begin by realizing that the effectiveness of the radio health talk is greatly over-rated.

The unseen millions hanging upon every word are largely a figment of the imagination. If health could be presented in terms of Ed Wynn, Clara, Lou 'n' Em, Amos and Andy, Easy Aces, or the Goldbergs, there might be something in the theory of vast audiences. That the average health talk creates no such interest is, in my judgment, indisputable.

The radio interview, in which two voices participate, is a shade better than the health talk, though even the interview can be deadly enough if unskillfully employed. In my judgment, the only way health messages can be presented effectively to the radio audience is to sugar-coat them with a bit of music and a dramatic presentation liberally sprinkled with humor and depicting characters that talk like you and me, instead of like a page out of a textbook. A lesson artfully concealed in such a relatively painless quarter-hour has a chance of being heard and, consequently, a chance of getting home. This is not as easy as writing a straight talk and then delivering it into the microphone, but it is far more productive.

To sum up, the radio is useful mainly for putting across broad, general ideas. It is very much like the billboard. How much goods the individual billboard sells will probably never be discovered, but there is no doubt that it builds up familiarity with the name of the product or service and thus makes the more specific advertising of greater effect. So with radio.

PUBLIC SPEAKING

The spoken word from the platform is like the radio except that it adds a more personal touch and by definitely limiting the audience makes it possible to be more specific, both as to subject chosen and content of the presentation. It is necessarily more limited, but in proportion as it can be used, it is more effective. And let me beg you not to visualize a personal talk purely in terms of the luncheon club or the semi-social study group. These are pleasant places in which to appear for health talks, but we must not neglect the factory, the mine, or the mart, and those other places where we can reach that portion of our community which has no contact with business men's service clubs, woman's clubs, or even in many instances with the Parent-Teacher Associations. The health talker must be as much at home on the soap box as he is on the palm-bordered rostrum if he is to be effective. He must be able to talk to boys and girls as well as to men and women. And he must be able to take care of himself without losing his aplomb or his good nature in a hostile setting.

PRINTED MATERIAL

The printed word is usually the first medium employed in health education. Millions of leaflets, pamphlets, bulletins, stuffers, throw-aways, stickers, and posters are used with a health educational motive every year. How many of these should never have been used or should not have been used in the way they were, may be visualized by the contrast I have given you between the literary gem which was a practical dud and the homely broadside which brought home the bacon. Neither I nor any other speaker can tell you in detail how to choose your printing. Perhaps you must learn from mistakes, but I submit to you that other people, including myself, have made enough mistakes to give you a liberal education and there is no occasion for each of you personally to make too many more!

It has recently been said by an educational expert, in answer to a question about what kind of type to use in a given message, that any kind of type can be made effective if one but knows how to use it. And 'et us not overlook the mimeograph and multigraph when printing is out of the question. A message worth reading will be just as effective by mimeograph as in type. I have seen some that beat printed matter in many ways. I wish every health educator could see the Fourth of July health message issued by a certain city health department in 1931 and its unusually clever want-ad issue of October, 1932.

These two examples are radically different and yet each is remarkably effective. Each has couched a health message in terms which are familiar to all because they have been employed so frequently in other connections, and each of them adds the spice of originality and cleverness in presentation.

BENEFITING FROM OTHERS

Finally, let me ask you if there is any good reason why you in your community should not make use of the educational successes which others have achieved. Public health workers, like physicians, do not usually patent or copyright their methods, or if they do, it is only to protect them against exploitation. They are universally willing and indeed happy to have their successful efforts copied. I do wish to remind you, however, that credit is due the author and the publisher when you lift a good piece of health writing and, of course, courtesy requires that you lift it not only with credit, but with permission procured in advance.

There are other devices such as posters, prize contests, souvenirs, and others too numerous to mention here, which can be employed in a health educational program. They are governed by the principles just outlined. In most instances a specific project requires the utilization not only of one, but of several promotional methods. Take, for example, a summer round-up in which the publicity media included billboards, street car dashcards, printed folders, celluloid buttons, souvenir balloons, personal letters, telephone calls, and the personal man-to-man—perhaps I had better say woman-to-woman—persuasiveness of public health nurses in the field. The program, needless to say, went over in a big way.

REMEMBER THE PRACTICING PHYSICIAN!

And last of all, let me caution you against the mistake that so many health educators have made and are still making. They are so prone to forget that the most valuable health worker in the community is the practicing physician. His group is the best trained group devoting its whole time to the preservation of the public health. That he still does most of it through the medium of treating the sick is true, but more and more medical practice is becoming the practice of prevention. Virtually everything that you say, everything that you do, everything that you attempt, is subject to the veto of the family physician, who will be consulted. If your program is sound he will not veto it; if it is not sound, he ought to veto it and he will. Before you start the development of your health education program, get in touch with your local medical profession and get the benefit not only of their goodwill, but of their sound judgment, their wise advice and their moral support.

The Five-Day Week

Department of Health, Los Angeles, California

By AGNES G. TALCOTT, R.N.

AS an official order of the City Council in compensation for salary reduction, the five-day week was introduced in Los Angeles on April 1, 1932. This was an effort of the Council to balance the budget. Theoretically, it was supposed to prevent the laying off of city employees but, so far, has not attained that end. A large number of city employees were dismissed and, while those who were retained are working shorter hours, they are of necessity compelled to carry an added burden of work.

ASSIGNING TIME

Time schedules are made out monthly, assigning nurses to clinics and days off duty. Every third month each nurse takes Saturday duty and is off some other assigned day of the week (Tuesday, Wednesday, or Thursday), so that for two months out of three every nurse has Saturday and Sunday together off duty. We have no clinics on Saturday and with one-third of the staff on duty all acutely ill and postpartum patients are visited, as well as all new cases reported to the department. Clerks also take their turn for Saturday duty, but are only on duty Saturday morning, and have a half day during the week.

Sunday and holiday duty: Only emergency calls and visits to perineorrhaphies or postpartum patients with other complications, are made. When Sunday and a holiday come together, all postpartum and bed cases are visited either Sunday or the holiday. Nurses assigned to Sunday and holiday duty are given equivalent time off. The staff is given all holidays in addition to Saturday off duty.

The salary cuts were as follows: Ten per cent for all salaries over $100 per month. In addition, the Health Department employees voted to donate approximately four per cent of all their salaries to retain Health Department employees who had been discharged by the City Council, due to the budget curtailment of July 1, 1932. The monthly payroll for the nurses is approximately $10,845—less, of course, the 10 per cent and the donation.

Our case load has increased. Fewer home calls are being made and time in clinics has increased. At present, we are studying the nurses' programs, hoping by some readjustments in departmental policies and procedures to offset, partially at least, the decrease in personnel and working time. At present there are employees in the Health Department who find it necessary to work overtime when the pressure of work becomes too great. This is especially true of executives.

RESULTS OF THE NEW SCHEDULE

Comparing the six-month period, April to October, 1931, with April to October, 1932: The staff had 270 days of illness in 1931, and 199 days of illness in 1932. These figures are for the same nurses. Probably they are not very significant. Comparisons over much longer periods should be made.

No rule has been made regarding outside employment. We do not know of any nurse who has attempted it.

Additional study: Several nurses are taking extension courses, but they did that before the five-day week became effective.

Many nurses comment on how much less fatigued they feel and how much more satisfactory their social life is. We hope that, when times become normal again, sufficient personnel can be supplied to make the five-day week permanent. The additional leisure is certainly beneficial.

The Five-Day Week

Department of Health, Detroit, Michigan

By GRACE ROSS, R.N.

THE five-day week which was put into effect in the Detroit Department of Health August first was the result of a 36 per cent delinquency in tax collections and the resulting adjustment to meet the decrease in the city's budget. It is estimated that the cost of living in Detroit has decreased about 16 per cent. The salaries of our nursing staff have been cut 10 per cent, plus 14.5 per cent, in the last two years. Before the cut our nurses who were getting the minimum staff salary of $1,560 per year were able to save $75 a year by very careful budgeting. The minimum salary is now $1,200, which 40 per cent of the staff are receiving. The present staff cut is obviously greater than the decrease in cost of living in Detroit. To save $75 even with the 16 per cent decrease in cost of living is of course impossible, and making ends meet is difficult indeed. I suppose one must be grateful for any work these days when pay is an uncertainty.

In view of the above situation and because all the nursing work of the Department could not be done even when working seven days a week, it seemed wise to limit service so that the energy and morale of the staff could be maintained. The Health Board cannot change conditions, but at least its staff is squarely dealt with.

HOW IT WORKS

With our present staff of 362 nurses, the reduction to a five-day week represents a loss of the work of 34 nurses. There is no set plan for the whole staff to follow; each Division and each district adjusts its schedule so as to get the most work done. We have found, however, that releasing the largest number of nurses on Saturday is the best plan, so that the Department may function as nearly one hundred per cent as possible during the rest of the week. We now cover emergency work on Saturdays, and, as usual, on Sundays and holidays. Emergency nurses' time is made up any day during the week. In generalized districts, Saturday duty is required of each nurse only three or four times a year.

The Tuberculosis Division must maintain a six-day program because of the children's clinics held Saturday mornings. To stagger the load, the nurse takes a half day on Wednesday and a half day on Saturday for one week, then the following week she gets all day Saturday off. Thus half the staff works on Saturdays.

In the Social Hygiene Division, the children's clinic has been combined with the Tuesday women's clinic, so that the nurses get their Saturdays free and no clinic has been dropped.

In Child Welfare, six Saturday clinics were discontinued. This was necessary as otherwise clinic hours would absorb follow-up visit time, which even in normal times they tend to do. Home visiting has been further reduced by

Extending the time between home visits: Prenatals from every two weeks to once a month; babies and preschools from every two or three weeks to every two months, unless some acute condition exists or arises.

Discharging preschool children from active field service when immunization against smallpox and diphtheria have been completed, unless some other very definite health problem exists.

Encouraging nurse-patient conferences in the clinic: Patients who are interviewed routinely by the nurse in the clinic are not visited in the home.

It is interesting to find no decrease in total clinic patients. They have simply changed their visiting day.

Group conferences with nurses which

formerly were held each week are now held every two weeks.

In School Nursing, because less home visiting is possible under the five-day plan and more time is needed for parent conferences, parent clubs, and health education programs, the number of days for visiting the schools has been cut by one or two days. This is especially true in the schools which had had daily nursing service.

We are glad of the opportunity to cut down the service time of the nurse in schools. With routine daily inspection by the teacher, this daily visit is no longer so necessary and the nurse is released to do more follow-up work. The limited schedule is strictly adhered to. School nurses are off duty on Saturdays, except those needed for the office or emergency field work.

The Health Department routinely takes five less holidays a year than city employees are entitled to. The other holidays we take regardless of the five-day plan.

The time for the two monthly general staff meetings is now donated by the nurses from their own time and the program this year is of their own choosing.

IS THERE ANY REDUCTION IN ILLNESS

The question of improved health of the staff because of the added rest cannot be fully answered at this time as there are too many factors that influence figures covering such a short period. However, in a similar period last year, fifteen nurses had already exceeded their fifteen days of sick leave; this year only eight have done so. When asked how they personally felt about the matter, 88 per cent of the staff (on unsigned reports) answered that the additional rest time had been a definite factor in improving their health and 86 per cent believe they are doing better work.

USE OF THE LEISURE TIME

Many of the nurses are happy to use the free time solely for resting; further study might show good reason for this choice. Many are using it for self-improvement. Exactly 50 per cent are using it wholly or in part for study; 42 nurses are carrying extra classes. Already six others are planning to register for more classes next semester, and four would like to but are unable to afford it.

Some nurses are taking field work in social hygiene; others in social case work; one has started a law course; seven are making up high school deficiencies; one has joined a botany club and many nurses added—"trying to catch up on cultural and professional reading." Two nurses would gladly supplement their income by paid outside work, if it were available, as no rules govern the use of their leisure time. Most of the staff feel they are already supplementing their incomes to some extent by doing work for themselves which would otherwise have to be paid for; housework, laundry, sewing, personal service, and as one nurse expresses it "quality shopping," all of which they never had time for under the old plan.

When asked whether they would want the half day back if they could be paid for it, they forgot they were *writing* answers and exclaimed "No!"—94 per cent actually recorded *no*. Among the reasons given was this one: "No, because it costs more to pay for cleaning than I would get. I am saving money by doing my own cleaning!"

In the not too distant future, let us hope that all workers will have time in which to live as well as to work. Any change meanwhile which tends toward that end is not only acceptable but laudable. It is to be hoped that no retrenchment follows.

Cleveland's Dispensary Admission Plan

By H. VAN Y. CALDWELL
Executive Secretary, Academy of Medicine, Cleveland, Ohio

When you find a patient in need of medical attention who has no family physician, what do you do? This is Cleveland's plan.

SINCE last July Cleveland has been experimenting with a new dispensary admissions plan formulated by a Joint Conference between the Academy of Medicine, the Welfare Federation, the Hospital Council, and governmental agencies. The plan proposes to relieve the dispensaries of some of their over-burden by returning to the private physicians an increased percentage of persons seeking admittance to out-patient departments.

A set of principles has been adopted whereby out-patient departments and social agencies including, of course, public health nursing agencies, agree to refer to private physicians patients who at one time or another have been under the care of a private physician. While there is no time limit set to this principle, it is understood that the plan does not apply to every new case but to those persons who, it is hoped, can return eventually to a self-sustaining status. Therefore, another of the principles included in the program is that agencies agree to refer to a private physician persons who now or ultimately might be able to pay at least in part for their service.

A central committee has been established with headquarters at the Academy of Medicine. This committee is representative of the agencies coöperating and acts as a board of arbiters in case of dispute and as a bureau of information as questions arise regarding details of the plan.

The committee furnishes to out-patient departments and agencies a set of blank reference slips in triplicate. One slip is retained by the referring agency, another is given to the patient to take to the private physician and a third is mailed immediately to the central committee for filing. If the physician decides that the patient should be forwarded to a dispensary, he so indicates on the slip which the patient presents to him. The patient then takes the same slip to an out-patient department. Out-patient departments send to the central committee all slips so presented. The files at the central committee office indicate that, of every one hundred patients sent by social agencies to private physicians, approximately twenty-five per cent are sent on to dispensaries. It is presumed that the other seventy-five per cent have remained as private patients of the physician. A study is now being started to determine whether this conjecture is entirely correct. However, there has been no evidence to show that patients have failed to get medical treatment, no complaints having been received from the public.

The physician who accepts a patient from an agency agrees to treat him for such fee as he and the patient agree is fair; or to treat him free or on a deferred basis; or to refer him to an out-patient department.

In order to make easy and quick reference the Academy of Medicine furnished to the agencies a list of its members who were willing to coöperate. These names were assigned against census tract areas throughout the city so that the distribution of cases would not fall too heavily on a few physicians. The first reference, of course, is to a family physician whether he is on the Academy list or not. Where there is no family physician, the patient or the worker or both together select a physician from the list. Reference is made by the worker on the case only to general practition-

ers, to obstetricians, or to pediatricians.

The plan has not been proposed as a cure-all, nor even as workable in other communities. In fact, it is but a re-emphasis of the old principle that the private physician is the first stronghold of the public and should be utilized wherever possible. Most agencies and most private physicians have been thoroughly coöperative. Wherever possible, agency workers have been making contact with private physicians to whom cases are being referred; and an interchange of ideas and understanding is taking place which is mutually advantageous. The private physician is being brought into the picture as an agency in the solution of community health problems.

The plan was not devised with the idea that the physician would reap a monetary advantage. In fact, in very few cases is the physician compensated for his work. A few patients pay part of a normal fee or are able to make arrangements for deferred payments.

The effect upon the out-patient departments is not easily measured. In some cases there has been a decrease in new admissions or in the rate of increase of new admissions. Several factors, however, may contribute to this decrease: the dispensary admissions plan; other plans devised by out-patient departments to curtail admissions; and the state of health of the community, which until recently was exceptionally good.

The advantages of the plan as operated in Cleveland may be summed up as follows: (*a*) a part of the dispensary load is being lifted; (*b*) many families are being saved for private practice who otherwise in their panic would have become dispensary charges; (*c*) a closer contact is being established between private practice and social agencies, with a better appreciation of each other's problems as a corollary.

ONLY THREE CENTS FOR HEALTH

One of the most striking charts in the recent final report of the Committee on the Costs of Medical Care shows how "Our Medical Dollar" is spent. Out of a total bill of $3,656,000,000 for 1929, only 3.3 cents in every dollar is spent for public health, $121,000,000, to be exact. On the other hand, we spend 3.4 cents or $193,000,000 on cults and quacks and 18.2 cents or $665,000,000 on drugs of which $360,000,000 is for patent medicines, for the most part worthless medication. Physicians (29.8 cents), hospitals (23.4 cents), dentists (12.2 cents), nurses (5.5 cents), and unclassified (4.2 cents) make up the remainder of the "medical dollar."

The American Public Health Association, from exhaustive study of the subject, lays down a standard of $2.50 per capita for public health in urban centers, and a somewhat larger expenditure in rural communities. On this basis the public health expenditures of this country should equal at least $300,000,000, or approximately 10 cents of the "medical dollar."

For two and a half decades the public health associations and allied groups of this country, in a non-official capacity and with meagre resources, have been organizing, educating, and demonstrating in every part of the United States that "public health is purchasable."

The American public needs the constant stimulus of some group or groups to keep up interest in any subject of common interest, even one so vital as that of the public health. That 3.3 cents offers a challenge to all who are engaged in public health work to let their friends and their constituencies know that at least three times as much effort is demanded, if we are to reach the desired goal of $2.50 per capita.—*Journal of the Outdoor Life.*

Relief-Giving in Public Health Nursing Agencies

Report from replies to Questionnaire sent out by the N.O.P.H.N. to Member Agencies

Editorial Note: A sketchy summary of the trend of the replies received on the relief-giving questionnaire was published in *Listening-In* in January. We are giving here the detailed statistical summary of the reports, and in addition to this information, we thought our readers would be interested in the general tendencies noted in the replies, and the many varied lines of procedure followed throughout the country.

These replies, as will be seen, cover all types of public health nursing services, widely distributed geographically. We only regret that rural one-nurse organizations and industrial nurses are not represented here.

REPORT ON RELIEF-GIVING

As always N.O.P.H.N. members have responded with enthusiasm to the request from headquarters for information, month by month, on specific present-day problems. The first question sent out concerned relief-giving, and as we promised, we are summarizing here the replies received from 208 agencies.

REPORT FROM 104 NON-OFFICIAL PUBLIC HEALTH NURSING AGENCIES

Agencies giving no relief at all	22
Agencies giving material relief	5
Agencies giving relief in relation to health	77

Among the 77 agencies, 26 report more extensive relief than in the past, 4 less, and 28 a change in policy in relation to kind and extent of relief-giving, 23 no change in policy or demand. Material relief used in this connection means food, clothing, rent, financial aid, etc. Relief in relation to health usually means milk, cod liver oil, layettes, medical and sick room supplies, emergency food, and carfare to clinics. There are still 54 agencies to be heard from.

REPORT FROM HEALTH DEPARTMENTS

In 51 Health Departments, no relief is reported by 34, some relief by 17. It takes the form of layettes, milk, cod liver oil, or clothing. An increase in free medical care is reported. There are still 80 health departments who have not replied.

REPORT FROM BOARDS OF EDUCATION

In 53 boards of education, 13 give no relief to school children; in 40, relief is given to school children through schools, which takes the form of milk, noonday lunches, free corrective care, school books, clothing, eye glasses, braces, or transportation.

Contributions toward this relief in schools come from school "charity funds," teacher contributions, Parent-Teacher Associations, Junior Red Cross, or civic clubs and organizations in the community. Among the latter are the community chest, relief funds, city welfare department, Kiwanis, "Dads Club," newspaper fund, etc. Of the agencies reporting, 13 report increased need.

As nearly as could be gleaned from the replies, the school nurses themselves are working with the local relief agencies, and are not distributing relief in person, although the situation involves much of their time in making decisions, home visits, and reports. Such social agencies as the following are used: Family Welfare Society, Needlework Guild, City Welfare Department, Red Cross, Mayor's Relief Committee, etc. The group most generally called on for help seems to be the Parent-Teacher Association.

Replies from 96 boards of education are still to come in.

In summary of all these reports—"no

relief being given" is reported by 69 agencies, some type of relief by 139.

GENERAL TENDENCIES

For the most part relief is given only in terms of its relation to the health of an individual. Milk, cod liver oil, a much increased output of layettes are the most common forms of relief. There is increased dependence by the community upon the nurses' knowledge of family situations and they are frequently requested to furnish the necessary facts as to home conditions. It is interesting that several agencies report that they are giving less relief than previously or no relief at all now, because local groups have been organized to handle the problem. School noon lunches have been added to the program in many places and school nurses are giving much time to home investigations. There is an increase in free dental and corrective work offered through the schools.

The Junior League is mentioned in many reports as providing funds for cod liver oil and milk.

As a rule, the few health departments that do give relief, give sparingly or only in emergencies. The emphasis is on the use of established relief agencies. Funds for special forms of relief come from outside agencies. For example, in one city, the Board of Health coöperating with the Mayor's Relief Committee furnishes milk to needy preschool children, cod liver oil to babies and preschools. Temporary material relief is sometimes furnished by health departments to communicable disease cases.

The actual distribution of relief by the nurse in person is being discouraged wherever possible. Families either come to the office, volunteers distribute, or some other department handles the goods—as in schools, the attendance department takes charge.

A good many organizations report the distribution of Christmas and Thanksgiving baskets and nearly every one, we are glad to note, reported that the names of recipients were cleared first through a central agency before distribution.

There is evidence that an increasing number of public health nursing agencies are being asked to supply medicines (fill prescriptions), braces and surgical dressings, etc., to patients. Frequently a community chest appropriation meets this need.

The Needlework Guild of America is a tremendously generous contributor to public health nursing groups, more than twenty reporting its donations.

Many organizations are requisitioning clothes from a central clothing bureau, donating all their clothing contributions to the bureau and thus avoiding duplication and the burden of handling clothing relief. The great exception to this rule is layettes. In fact, the very general custom of handing over the distribution of layettes to the nurses makes one inclined to classify them definitely as medical relief.

Some note should be made of the number of agencies that report supplies of cod liver oil, milk, and drugs donated by the manufacturers or local commercial concerns. If these donations were estimated in cash for the country over they would run into very large sums.

Throughout the reports there was unanimous approval of the closer relationships among local social agencies. Apparently the goal of joint planning for community welfare is much nearer than before the depression.

No actual cash is being given by the great majority of public health nursing agencies except in emergencies—and this in very small sums.

As has been noted in our summary, few organizations have made radical changes in their relief-giving policies. Several executives are quite emphatic in their attitudes: "We have not changed our policy. We give no relief." "We never have given relief and do not expect to."

It is gratifying to find that the emergency situation has not—at least in urban communities—thrown us back into the period when public health nurses, the "district nurses" of those days, struggled to meet the material needs of their patients as well as all their physical difficulties. The confu-

sion in the patient's mind, the disruption of the case worker's plan, the weakening of the nurse's position and the possible duplication of effort resulting from the nurse's intrusion in this specialized field, are evident. We quote the N.O.P.H.N. *Manual* on this point:

> The public health nursing agency should not give general family relief except as an emergency measure to avoid suffering during the interval which must elapse between the report of the case and action on the part of the relief agency. It is important that the patient regard this as an emergency measure and not as a legitimate service of the nursing agency. It is, however, within the province of the nursing agency to furnish certain medical necessities to those patients whose families are unable to secure them and who are not under the care of other agencies. These may include milk, eggs, special invalid diets, medicine, medical and surgical appliances, provision for convalescent care, etc.
>
> If there is no relief agency in the community, the public health nursing agency should appoint a social problem or case work committee to administer the relief even though recommendations for type and amount of relief are given to the committee by the nurse. The personnel of this committee might be chosen from various church and fraternal organizations and from the Red Cross, and if possible should include a member who has had case work experience.*

VARIED PLANS IN RELATION TO RELIEF

Some of the relief reports noted situations or procedures a little out of the ordinary. A few of these are listed here to give a bird's-eye view of conditions.

NON-OFFICIAL PUBLIC HEALTH NURSING AGENCIES

One agency gives bags of food, pays gas bills in emergencies, supplies clothes and milk tickets. This plan is new to the Association, was talked over with the relief agencies, and is regarded as necessary since many patients are cold and hungry and constructive health teaching and nursing care in the home are otherwise impossible.

Another reports an unusually large relief program including convalescent care, braces, orthopedic shoes, milk, medicine, layettes, coal, clothing, renovated garments, and emergency orders for food, coal, and bedding when immediately needed in cases of illness. Approximately $5,000 has been used in eleven months for these purposes, half of the money coming from the community chest, half from special funds. A social service committee of the board and staff authorizes these expenditures. (This city was completely without relief funds during the summer. However, this is not a new policy of the agency—only one used to fuller extent than ever before.)

An emergency food closet is maintained in one organization containing canned fruits, soups, jelly, cocoa, dried milk, jello, and canned vegetables. These are for sick people, to bridge the gap between the nurse's visit and the regular relief food order.

In another city, in case of an emergency need for food, a nurse may purchase milk, bread, eggs, etc., to the amount of $1.00 to tide over until the relief agency supplies food. (Several other agencies report similar emergency funds.)

In a very small way one association has sponsored a full time nursing service for very sick patients—the work being given to unemployed nurses.

Another used unemployed nurses for very ill patients on the basis of the "made-work" plan, the nurses being paid for their service from relief funds.

HEALTH DEPARTMENTS

Staff nurses have been distributing seeds for kitchen gardens to patients who can and will use them to advantage. This is a southern city!

In several cities, staff nurses are investigating all cases reported by the unemployment relief bureau as needing nursing care.

One department of health secures bread and rolls from wholesale bakeries and delivers at certain schools, for undernourished, destitute children. In this city, dispensary treatments have jumped from 90,000 to 400,000 and prescriptions from 100,000 to 400,000 in less than four years.

*N.O.P.H.N. *Manual of Public Health Nursing*, The Macmillan Co., $1.50.

One city reports that giving relief was formerly on a scattered, individualistic basis. Emphasis has been laid on clearing through the official relief-giving agency. This effort includes the schools and P.T.A.'s. Results are good from this centralized plan.

BOARDS OF EDUCATION

A Central Relief Committee has been formed giving pupil and family relief in a large city. In each school there is a relief committee consisting of two teachers and the school nurse. All cases of relief are cleared through the Social Service Exchange. In 1931, $20,000 was spent on relief. This year an equal sum is anticipated and the teachers and Welfare Federation contributed to the fund—the teachers by far the largest amount. Relief consists of shoes, clothing, milk, and hot lunches. Each school has a group of investigators and close coöperation is maintained with all city social and relief-giving agencies. The school nurses attend the district meetings of the social agencies regularly.

In another city, in coöperation with and at the suggestion and expense of the community chest, the board of education is feeding 650 children daily in school cafeterias. Conditions are carefully investigated before admitting children to this plan.

One city reports a benefit football game, which netted $4,281.15 and provided milk for needy children in school.

Several cities report that needy children are allowed to work in school cafeterias in exchange for their lunches. In another city, in a few selected instances children are sent home for lunch with another pupil whose parents are willing to help in this way.

A city reports that the medical care given through the school health department is financed by the community chest fund.

A teachers' association has pledged $17,644 for relief work, a large amount of which has gone to the city relief agencies. Hot lunches, however, are being provided to 300 needy children. Food is bought at wholesale and stored at a central school. A committee of home economics teachers plans the menus.

Through the courtesy of the American Red Cross we are summarizing replies to a questionnaire sent to Red Cross Services:

Through the influence of the public health nursing service, 43 chapters formed welfare committees during 1930-32. In 29 services the nurse does social work, in 20 volunteers carry it on, eight employ a social worker.

A Supervisor on the Inside Looking Out

By LESLIE WENTZEL R.N.

SUPERVISION is democratic leadership. The supervisor's objective is to establish and maintain the machinery which will make it possible for the staff to work most efficiently and effectively.

The supervisor cannot be too well equipped for her position. She should have a sound professional background, post-graduate training in the public health nursing field, preferably experience in other phases of nursing and above all she should be essentially a teacher, knowing well the principles of teaching. In addition to the qualities which one desires in every public health nurse, the supervisor should have endless patience, the gift of leadership, and be able to work harmoniously with others. It is most important that she be tolerant. She must have confidence in herself and in others and she is not complete without imagination and vision, well balanced judgment, common sense and a saving sense of humor! This ideal supervisor is not critical of effort if the nurse has done her best, for we have passed the stage of destructive criticism.

THE SUPERVISOR AT WORK

Concretely, it is the supervisor's responsibility to teach the technique and policies of the association; to safeguard the fundamental principles of public health nursing; to standardize nursing procedure; to determine the adaptability of the individual to public health nursing, and to develop, in so far as she can, the capacities of the individual nurse.

"Why do you need supervisors?" a new board member will occasionally ask. "The staff nurses seem to be very well trained. Are they not capable of solving their own problems?" Occasional complaints are registered also by the uninformed about the cost of this "unnecessary" person.

Let us visualize the supervisor at work. We see her in the office between the hours of 8 and 9 A.M., assisting the nurses in planning the day's work. She is responsible for seeing that the nurses' case-loads are intelligently carried, and evenly distributed, that the seriously ill patients and maternity cases are seen in the morning and that all patients receive expert nursing care. One nurse in her zeal may take more cases than she can skilfully handle, and another nurse may be inclined to shirk, so that it is the supervisor's duty to see that the staff is not over-worked or under-worked.

The supervisor, through her knowledge of the community, is able to point out to the nurse how she can decrease travel time and in many ways, during the day, eliminate waste and energy, both of which add to the expense of the service. The new nurse especially needs help in the planning of her work. The supervisor confers with each nurse about the previous day's visits, the new cases, the acutely ill patients, or the problem case. Perhaps she helps the nurse decide whether or not the case should pay the full cost of a visit, or what social procedure should be followed in handling family problems. Throughout her work with the staff, the supervisor tries to direct the attitude of the nurse toward constructive help for her patients, based on sound principles of mental hygiene so that the nurse does not become discouraged with or over solicitous for her patients.

The supervisor does not attempt to acquaint herself with every patient in the case-load, but she should know the seriously ill patients, the new maternities, chronics, and cases with special problems. She should be able to say to the nurse, "How is Mrs. X? Has she had her crisis? Has Mrs. B., the prenatal with marked edema, been to see a doctor? Is Mrs. Y.'s baby taking the

lactic acid formula ordered by the clinic physician?"

The supervisor is responsible for seeing that the nurses make the proper contacts with other social and health agencies. Joint case-conferences may be called by her if necessary.

FIELD SUPERVISION

The nurse is also supervised in the field. The supervisor may visit with the nurse, may go to give care without the nurse, or may supervise in clinics. The supervisor is careful never to criticize the nurse's technique or shortcomings in the presence of the patient, or to say anything that will destroy the patient's confidence in the nurse. As the supervisor becomes familiar with the background of her nurses, and their grade of work, she will know whether it is important to visit with certain nurses intensively, weekly, monthly, or less often. The supervisor has a schedule which she tries to follow, but there may be reasons for a change, as, for instance, when a nurse who has been on the staff some time becomes careless in her technique, or when a young nurse is having difficulty in seeing the family as a whole and has not been able to transfer her hospital training to home situations, or when a nurse has a special problem, or is giving good care, but needs to be "bolstered up" from time to time; and then there is the nurse who is trying out a change in technique.

After visiting in the field, the supervisor writes up a field supervisory sheet, and discusses it with the nurse the following day. At this time she assists the nurse to analyze the previous day's work, and tries to strengthen her weak points, being careful not to attempt to get too much across at one time. If she is wise, she will select the most important points and emphasize them, bearing in mind always the quality of being a good listener. During this interview the supervisor has before her the records of the cases visited, which also give her an opportunity to review her record work with the nurse. Records may serve as one of the most constructive avenues of supervisory advice. In making criticisms the supervisor should be conscious of the fact that she is working for self-confidence on the part of the nurse, so she must stress good points as well as tactfully pointing out where the nurse needs to improve. Criticism should be constructive, and this implies not only suggesting a means of improvement, but suggesting it in such a way that the nurse is prompted to try it. This interview should leave the nurse with the feeling that the supervisor has something to offer, that she can be depended upon for wise counsel and good judgment; that she has confidence in her—the staff nurse—and expects her to improve. The nurse should leave the interview determined to do her best.

Efficiency records are compiled from the field supervisory sheets, usually after a period of six months. They are important for the following reasons: to show the general improvement of the nurse, the general improvement of the service; to stimulate and inspire the nurse to analyze her own work; to use in recommending the nurse for another position.

Field supervision is important from other standpoints: It gives the supervisor a chance to see the nurse's approach to the home, her patient's reaction, the family's reaction to her visit, the actual conditions in the home which may influence the plan of care for that family (as for example in the case of a patient being carried longer than necessary or not seen often enough) and it gives the nurse a feeling of joint responsibility—she knows she is not working alone. Finally, the extent to which the agency's program is being developed is evidenced in the nurse's interest in the aims of the service. For example, how is the nurse developing the following situations:

The physical examination of all preschool children in her district
Toxoid for all children in district under four years
Knowledge of all resources within district and community
Early registration of prenatals
Relationships with midwives in the district
Economy of time and supplies

Use of Public Library
Knowledge of tuberculosis and contacts, and returns for examination.

In short, the field visit reveals the initiative, self-reliance, intelligent independence, and successful assumption of responsibility for the community's health on the part of the nurse.

HOW TO JUDGE SUCCESS IN SUPERVISION

If the duties of executive and supervisor are merged in one person, as is frequently the case in staffs of less than six nurses, who is to judge whether or not a supervisor measures up to the goal set for her? The board may ask: Is she the person we want? Is she capable? Is she efficient?

There are many ways of judging the supervisor: The staff is the product of her teaching—is it successful? Do the patients like the nurses? Do the doctors approve? Has the supervisor made herself felt among the general public? What is her impression on the board of directors? On other professional groups? She must give evidence of being a well organized person herself, capable of planning ahead. One of the most serious criticisms of a supervisor, it seems to me, is to say that she is incapable of differentiating between the important and the unimportant. She may lack definiteness of purpose, she is too detailed, she becomes so involved and swallowed up in the rush of emergency work that she does not accomplish her goal.

Is this sufficient evidence to convince the inquirer that all public health nurses are not supervisory material? That even if all were supervisory material, there would still be need of one person in charge, with a bird's-eye view of the whole, to direct and plan the program and stimulate the staff? Indeed, experience has proved that such a person—be she called director, supervisor, or nurse-in-charge—is needed on every staff of more than one nurse. Even the nurse working alone craves outside advice and seeks it through her State Department, a nearby urban organization, or the N.O.P.H.N.

These remarks are not intended to minimize the important rôle of the staff nurse. She is the very structure on which we build. She is indispensable; she is invaluable; but she has a very difficult task, and it should be the supervisor's chief interest to lead her into self-direction and self-dependence, to reach her maximum effectiveness and happiness.

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR FEBRUARY, 1933

Psittacosis ..... Charles Armstrong, M.D.

The Hunger Strikers ..... Gertrude I. Thomas

Sling Used in Postoperative Treatment of Thoracoplasty, Alanson Weeks, M.D., and G. D. Delprat, M.D.

Nursing the Pernicious Anemia Patient ..... Madge T. Little, R.N.

Care of the Hair ..... H. H. Hazen, M.D., and Florence Biase, R.N.

The Fifth Decade ..... Bertha Van Hoosen, M.D.

Fewer Schools but More Students ..... May Ayres Burgess, Ph.D.

Chemistry Indispensable to the Nurse for Understanding the Body in Health ..... L. Jean Bogert, Ph.D.

Final Report of the Hourly Service in Chicago

Editorial Note: From time to time we have noted the progress of the experiment in Hourly Appointment Service in Chicago under the auspices of a Joint Committee of the First District Illinois State Nurses' Association and the Central Council for Nursing Education, assisted, since 1931, by the Rosenwald Fund.* We are delighted to be able to offer to our readers a summary of the final report of the executive director, Miss Miriam Ames, and conclusions, with comments by Dr. Michael M. Davis, Director of Medical Services of the Rosenwald Fund.

THE period of the experiment extended from January, 1931, to June, 1932.

The primary objective was to determine the usefulness of nursing by the hour for patients who did not require, or were unable to afford the service of a nurse by the day, and special emphasis was to be put on educational publicity. It was hoped also that the unemployment situation among nurses would be slightly relieved through a better distribution of nursing service, since extensive use of hourly appointment care would provide nurses with part-time work.

The economic situation was directly reflected in the figures for the last six months of the year 1931 and the first six months of 1932, when the experiment ended. The general unstable financial situation continued to become more acute. A number of the patients were unable to pay the hourly nurse's fees. These patients were referred to the Visiting Nurse Association. Some made arrangements for care with practical nurses, relatives, and friends. The work in the experimental area suffered from the effects of numerous bank failures.

Another reason for the decline in the service was its diminished news value. There was nothing spectacular about the development of the service to make a good story. Between the time when the service started and its close, there was a decrease all along the line: in new cases, number of patients under care, visits, hours worked and, of course, fees earned.

By the time the experiment had been under way for a year there were few persons who had not been touched by the financial situation one way or another. Salaries were cut, personnel dismissed, prices slashed. To meet the needs of the changed economic conditions, the Hourly Nursing Service made possible, in addition to its regular appointment service, a non-appointment service with a reduction of 50 cents for the first hour or fraction, and 50 cents for each additional half hour. The new rates went into effect March 15, 1932, and made good publicity. All patients were told that they might have the less expensive service, but the majority preferred to pay 50 cents more for the convenience of an appointment.

There were 25 non-appointment cases under care in the four months following the reduction of fees. From an administrative point of view the additional non-appointment service offered a better distribution of the staff nurse's time because she could make non-appointment visits between appointment visits in the same neighborhood. Then, too, the non-appointment visit could wait until the afternoon, never so busy as the morning.

DISTRIBUTION OF APPOINTMENT CALLS

Morning		*Afternoon*		*Evening*	
8 o'clock	16	1 o'clock	31	6 o'clock	8
9 "	110	2 "	43	7 "	10
10 "	99	3 "	33	8 "	28
11 "	65	4 "	25	9 "	9
12 "	17	5 "	4	After 9	4
	307		136		59

The success of hourly nursing service financially depends almost entirely on keeping a reasonable working week fully occupied. When the heaviest demands are for nursing care during the early morning hours, more nurses must be

*For the most recent report of this experiment, see PUBLIC HEALTH NURSING, January, 1932.

available in order to render an efficient service. If the volume of work is small, it is impossible to keep the staff nurses fully occupied during an eight-hour day. The average visit lasted seventy minutes and the average number of visits a day was four. The addition of a non-appointment service, which permits the nurse to distribute the visits throughout the day, was a partial solution to the problem.

Factors commending the service to the patients were the continued care by the same nurse, almost without exception, throughout the course of illness, the convenience of appointments, and the promptness with which they were kept.

OTHER FINDINGS

Few social problems were anticipated among the cases and few were found. A study of occupations was made from the case histories. They were classified as follows: Mercantile, 31 per cent; retired, 21 per cent; professional, 16 per cent; artisan, 15 per cent; unknown, 17 per cent. The latter group was composed of one- and two-visit cases where the information was not obtainable.

The following tables show the condition of the patient at time of dismissal:

CONDITION ON DISCHARGE

Recovered	13%
Improved	49%
Unimproved	27%
Dead	4%
No illness	4%
Still carrying	3%

DISPOSITION OF CASES

Dismissed to		*Cases*
Family or self		352
Hospitals		24
Dead		19
Other care		106
Special nurse	64	
Practical nurse	21	
V.N.A.	21	
Still under care		13
Total		514

It appears from this analysis that special nurses benefited more than others, when a case was dismissed. The fears expressed by a few special nurses that hourly nursing would deprive them of their livelihood, were ungrounded. The transferal of cases to both visiting nurses and special nurses indicated close coöperation.

As time progressed, evidence accumulated to show that the man in comfortable circumstances was patronizing hourly nursing much more than the man of moderate means. To ascertain the income of those using the service was out of the question. Other factors had to be used as a basis for the classifications. Four classifications were used: Eleven per cent were *in poor circumstances;* 27 per cent had *moderate means;* 32 per cent were *comfortably well off;* and 30 per cent *wealthy.*

FINANCIAL RETURN

The amount earned in one year by the entire staff, associate and regular, was $7,402.50. Dividing this sum by the actual number of hours spent on calls, 4,017.8, gives $1.84 as the average earnings per hour. The average daily collection was $8.57, computed for the year, $2,675. At this rate a staff nurse, working a full day, can be expected to earn her own salary and expenses, estimated at $2,175 a year ($1,850 salary, $325 expenses). This leaves a surplus of $500 per nurse to be applied to the overhead expenses of supervision, publicity, and central office expense. At this rate, according to the Chicago set-up, a staff of eight regular nurses and eight associate nurses would have to be kept busy to make the organization self-supporting.

The number of cases of acute illness outnumbered those of chronic illness, but fewer visits were made to the former and the cases were of shorter duration. It is important to know that hourly nursing served the chronically ill to such an extent. Why, among the acute illnesses, there was so little work with children, it is impossible to say. Only one delivery was attended during the experimental period and there were very few postpartum cases. Only minor communicable diseases could be cared for under the hourly nursing plan on account of the Health Department regulations.

CONCLUSIONS

1. The economic depression did not result in an increased demand for hourly nursing among "persons of moderate means," as had been expected. Persons in comfortable circumstances and the well-to-do used the service most freely. The service was most popular among those who could afford to pay for a full-time nurse, but who did not need one.

2. The most effective type of publicity for hourly nursing was not in the newspapers or other media reaching large numbers of persons, but was achieved through physicians and hospitals. Personal contacts with physicians in home or offices, explanatory talks before groups such as hospital staffs and members of medical societies with the free distribution of literature, brought more returns than any other form of publicity. Increased interest on the part of physicians, their courtesy and helpfulness in advising the use of the service among patients were noteworthy and indicated the confidence placed in the nursing staff.

3. Hourly Nursing Service cannot be self-supporting on a small scale unless an already existing organization shares the overhead expense. The cost of service when administered as an enterprise separate from that of a general districted nursing service, is comparatively high. A considerable proportion of the nurses' time must be spent in travel. The concentration of calls from patients for the same period of the day also makes it difficult to keep an even flow of work for a staff specializing in hourly nursing.

4. A lay committee acting in an advisory capacity was of great value in the experiment in securing both financial support and the coöperation of physicians, hospitals, and the press.

5. Service by appointment at specified hours would seem an essential feature of hourly nursing. The brief experiment with non-appointment service did not prove particularly popular, although somewhat less expensive.

6. The use of associate nurses supplementing the staff nurses was found to be of great value both as an administrative device and as a means of giving a certain amount of work to qualified nurses who would otherwise have been unemployed.

7. There is a real demand for hourly nursing in Chicago, but not of a sufficient amount as yet to have any substantial effect upon unemployment among nurses.

8. The experiment demonstrated the importance of centralized administration and supervision; the use of uniform, up-to-date records; the careful assignment of cases and strict adherence to well-defined policies in regard to fees, nursing procedures and ethical relations.

The results obtained did not justify the continuation of the experiment longer than the trial period of a year and a half. Undoubtedly the usefulness of the service was limited owing to unforeseen economic conditions, but sufficient response was met to indicate that hourly nursing service is desirable and a community need.

The First District Illinois State Nurses Association is assuming the responsibility for carrying on the service for one year from October, 1932.

THE MEANING OF THE HOURLY NURSING EXPERIMENT IN CHICAGO*—COMMENTS BY MICHAEL M. DAVIS

IT may be well to supplement Miss Ames' excellent report of the hourly nursing experiment in Chicago with a statement prepared from the point of view of an observer of the undertaking, who had the opportunity to be closely in touch with it and who has been deeply interested.

This experiment seems to me to demonstrate both a real demand for hourly nursing service and also certain limitations. It is clear that there is not only need, but an actual demand for nursing service in the home on an hourly basis; that only a small number of persons are as yet sufficiently familiar with the idea to call for such service, and that only a few physicians are as yet well enough informed about it to seek it in behalf of their patients. It has become apparent, on the other hand, that this demand can be increased through educational measures and that physicians and hospitals in particular are the channels through which this educational effort can be most effectively expended. The total amount of hourly service demanded by a given population will be relatively small in terms of the number of nurses employed, but hourly nursing is none the less a

*Appearing also in the *American Journal of Nursing* for February, 1933. See this number also for Miss Ames' detailed report.

needed and highly important supplement to full-time private duty service on the one side and to public health nursing on the other. Nursing interests and organizations, therefore, in fulfilling their responsibilities to the public have an obligation to develop hourly nursing service.

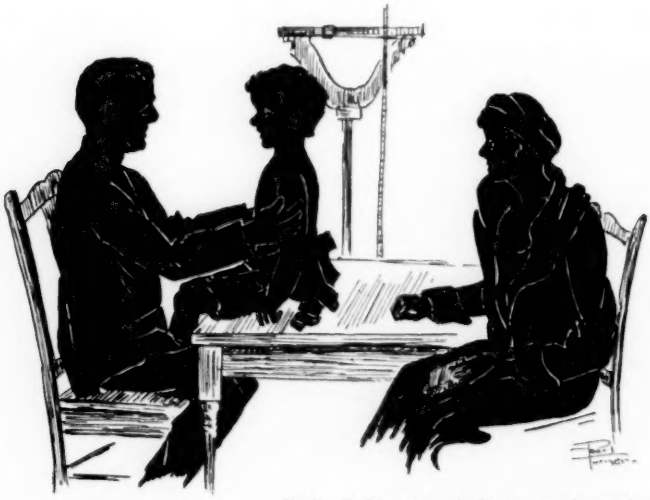
I am led to one major conclusion as a result of the Chicago experiment, namely, that hourly nursing service cannot be successfully carried on by an organization maintained for this especial purpose or in conjunction with a nurses' registry. There are two reasons for this conclusion which have appeared from the Chicago experiment. The first reason is financial. Miss Ames' study demonstrates that to make the service even approximately self-supporting, there must be a large staff of nurses. The expenses of administering the organization with an executive for supervision and promotion, and central office expenses, must be met from the surplus of earnings of the staff nurses over and above their salaries and incidental expenses. Unless the staff nurses are actively engaged in hourly nursing for the larger part of their working time, there is no surplus, and even with a full flow of work, the surplus earnings per nurse can amount to only about $400 a year at the hourly rates charged in Chicago ($2 the first hour, $1 for succeeding hours, for an appointment service). These rates cannot be increased, since it is a question whether they are not already too high for the pocketbooks of many persons who would like to use the service. Consequently, to make a central budget for supervision, the maintenance of a central office and incidental expenses of promotion, up to a total of $4,000, at least ten nurses would be required working on full time, or in practice a considerably larger number. There is every reason to believe that even in prosperous times, and in a city as large as Chicago, an organization this size could not be independently maintained for hourly nursing service without a large and permanent subsidy upon which to depend for financial support.

The second reason is that the maintenance of an independent organization for hourly nursing, with a considerable staff of nurses, would violate the principle toward which public health nursing has been working eagerly for many years—that of generalized, districted service. There has been a long struggle to do away with specialized nursing organizations. The generalized nursing service has won its way, and the principle of generalization should not be violated in terms of the social and economic groups which are furnished service, any more than it should be in terms of the medical specialties which are covered.

The conclusion that hourly nursing service cannot be successfully maintained under an independent organization, raises the question—what is the alternative? There seems to me only one answer: Hourly nursing service should be developed as an integral part of a general public health, or district nursing organization. I am aware that such a development faces difficult psychological problems. The background of public health nursing organizations is charitable, while hourly nursing is a service for those who can and should pay their way. It is interesting, however to bear in mind that another important type of medical organization has met this same problem within the present generation, and has solved it—*i. e.*, the hospital. A generation ago hospitals served only the poor. Today hospitals take all economic groups of the population from the rich to the destitute. Yet, despite the entrance and even the dominance of the paying patient in the voluntary hospital, the voluntary hospital in America has retained its philanthropic status and its hold on public-spirited people who have remained willing to contribute to its support from private funds or to vote its support from taxes. If the American hospital has done this, the American system of organized nursing service can also adapt itself in the same sense, and become a community instead of merely a philanthropic service.

Progress of the Summer Round-Up

By LILLIAN R. SMITH, M.D.



National Congress of Parents and Teachers

IN 1925 a movement was launched by Mrs. A. H. Reeve, President of the National Congress of Parents and Teachers, which has steadily grown from year to year until now the Summer Round-Up is generally recognized as one of the most constructive projects for the promotion of child health. Public health nurses have been actively interested in this project from its very inception.

Prior to 1925, Mrs. Reeve had visualized the value of sending children to school as free as possible from remediable defects and had observed the outstanding work done in California and Georgia in 1924. She realized that the most effective time for correction of defects was as early in the summer as possible so that the child might enter school in the Fall in good condition. With her characteristic force, she determined to start a nation-wide project under the leadership of the National Congress of Parents and Teachers, and the first call went out to the states in July, 1925. The work was further stimulated, this first year, by the offer of five hundred dollars to be divided among the three local associations developing the best methods and achieving the best results. While the giving of prizes doubtless acted as an incentive, the following quotation from a local president's letter expresses the general reaction of the associations which entered the contest, for such it was at that time: "When we started out we were working for the prize, I am ashamed to say, but when we got into the work and saw the results and the good we had done and will do for our community, we were truly ashamed to think a prize had to be offered to 'wake us up,' and no one mentioned 'prize' all during the entire work."

Accurate statistics are not available for the first year as reports were incomplete, but twenty-two states were represented among the registrations and in sixteen of these states, fifty-two associations completed the Round-Up according to campaign requirements.

The first prize of $250 was awarded to the Barrow School, Columbia, Mississippi; the second prize of $150 went to the Putnam Washington School of Marietta, Ohio; and the third prize of $100 to the Baker School of Austin, Texas.

The American Medical Association, the National Education Association, the Children's Bureau, and the United States Bureau of Education publicly recognized the value of the project the first year of its adoption and have continued to give valuable support and assistance.

INTEREST OF OTHER NATIONAL ORGANIZATIONS

From the very first, public health workers saw the possibilities of the plan and public health nurses were among its staunchest supporters and were particularly helpful in the details of organization of clinics with which many parent-teacher members were not familiar. Public health nurses also helped greatly in making the right contacts with the medical and dental professions so necessary to the success of the work. This coöperation from the nurses has continued through the years and has greatly strengthened the results achieved.

Early in the development of the Summer Round-Up came the realization of the need of advice from individuals specializing in the various branches of child health. As a result, there has been built up an Advisory Committee made up of representatives from the following groups: American Medical Association, National Organization for Public Health Nursing, United States Public Health Service, United States Children's Bureau, American Child Health Association, American Public Health Association, National Society for the Prevention of Blindness, American Red Cross, National Association of School Physicians, National Committee for Mental Hygiene, State and Provincial Health Authorities of North America, United States Bureau of Education, National Tuberculosis Association, American Dental Association, and American Federation of Organizations for the Hard of Hearing. This is a long list and an impressive one. The committee is most active and helpful in its advisory capacity. It meets annually, goes over current material, studies annual reports, and recommends to the National Congress such changes as it considers advisable from time to time. As a result, the policies of the Round-Up have kept pace with the accepted trends in child health.

The primary interest of the Round-Up was in the physical health of the children who would enter school for the first time in the Fall. After several years of concentrating attention on physical defects, the Advisory Committee recommended that attention be given also to the mental development of the child, and questions were added to the Physical Inspection Form which call the attention of the examining physician to the mental health of the child.

USE OF AWARDS

Mention has been made of the prizes offered in 1925 by the *Delineator*. In 1926, the National Congress of Parents and Teachers offered prizes aggregating $525, but after the first two years the awards consisted of certificate awards to local units and medal awards to state branches for results accomplished.

It has been found that the giving of state awards for the largest percentage of children immunized against diphtheria and vaccinated against smallpox has stimulated the giving of these preventive treatments. These awards for preventive treatments were first given for the 1931 campaign, during which 18,482 children were immunized against diphtheria compared with 9,908 in 1930, and 26,756 children were vaccinated against smallpox compared with 18,872 in 1930.

The results of the 1932 Round-Up are not yet tabulated, but in 1931 there were 47 states represented among the registrations as compared with 22 in 1925. Also in 1931 there were 2,739 local units which carried through the Round-Up compared with 52 associations accomplishing this in 1925.

EMPHASIS ON PARENTAL RESPONSIBILITY

Each year the local campaigns are planned with more careful attention to detail and with correspondingly better results. In the earlier years, attention was paid particularly to the number of defects discovered and corrected, but

gradually there is developing a consciousness that the value of the Round-Up is not in the number of defects discovered and corrected but rather in the number of parents who have assumed the responsibility for the health of their children.

The possibilities of the Round-Up as an educational factor have hardly been realized as yet, but local associations are beginning to see that it offers many opportunities. They are securing posters on foods, habits, prevention of disease, prevention of accidents and similar health subjects and are displaying them in the rooms where the mothers wait with their children at the time of the examinations. They are also having talks given to the mothers on different phases of child health by doctors and nurses, and some very helpful discussions have followed these talks. Groups of mothers have been particularly interested in talks on mental hygiene.

Individuals and associations are also becoming aware of the fact that it is too late to wait until the child reaches school age before having him examined and given the necessary treatments. This is indicated by the fact that requests are being received for permission to include younger children in the Round-Up. This they are always encouraged to do. Other associations bring in for examination children already enrolled in school who for some reason have not had the routine school examination.

WHAT PUBLIC HEALTH NURSES CAN DO

It might not be amiss in this article to mention briefly the contributions which public health nurses can make and already have made in many communities.

First—Nurses are most desirable as members of Round-Up committees, state or local. They should not be asked to act as chairmen, because the tendency so often is to leave too much responsibility on the chairman if she is a nurse. As a member of the Round-Up Committee, the public health nurse can see that the proper contacts are made with the medical and dental professions. Where such contacts are not made, misunderstandings may occur and have occurred in the past, in some instances seriously handicapping the work.

Second—Public health nurses are invaluable at the time of the examinations, if they are done as group examinations. The nurse should be free to assist the examining physician and should not be expected to take charge of details that can be managed by lay workers. She can give very valuable help by insisting that the examining physician be given sufficient time to go over each child satisfactorily and discuss his findings with the mother.

Third—There is one committee on which the public health nurse may justly be asked to serve as chairman, and that is on the follow-up committee. The home calls that are made on the mothers of children who have been examined often determine to a large degree the success of the campaign. A nurse as chairman can instruct a lay group as to the most effective methods of making home calls, and, in small communities, she herself may make some home calls, but here again she should not accept too much responsibility.

Fourth—The fall check-up to determine whether the children have received medical, surgical, or dental care during the summer (if such was recommended) may best be done by the school nurse by examining the signed slips brought in by the children. At the time of the examination, each parent is given a slip on which the recommendations of the examining physician and dentist, with space below for the signature of the physician or dentist who later gives the corrective treatments. In this way, the need for a second examination is obviated and the work correspondingly simplified.

This brief history of the Summer Round-Up brings out the strategic position which the public health nurse has played and continues to play in this nation-wide attempt to improve the health of children.

Moments *

By EDITH E. McCARTHY

THERE are moments when life, bearing too heavy a burden, is at the breaking point and such a moment had come upon Elsie Clark.

Not that she was in bitter despair. It was not in her nature to be bitter. She was convincing herself that she had failed, and failed at a job that she had undertaken with the highest hopes and dreams.

It was only a year ago that she had come to 18 River Street as a bride, and the stepmother of three children. She had come knowing that life would not be easy there, that the children would be prejudiced against her, and that there would be little money. But she had been prepared to do her best, confident that she could make the children like her and that the little sum she had saved would take care of extra needs.

Now a year had passed and she was admitting failure.

At first she had refused to notice when Jo muttered under his breath or Chester purposely forgot to bring up the wood; and she tried not to feel hurt that Christine avoided her, keeping her confidences for her father. But the children's hostility was increasing now that they guessed a new baby was coming—a baby that would be, as they saw it, neither brother nor sister to them.

It was her husband, John, however, who was causing her the most worry. Usually so cheerful in his own quiet way, ready to turn troubles inside out to display their silver lining, he had become a man she no longer knew—morose, nervous, even irritable. What could she expect, however? He had been out of work for six months and was not a person graciously given to idleness. Next week's food would take their last dollar.

Dr. Grayson had told her she was anemic and must build herself up with nutritious food. What was going to happen to her? Would she die? Would the baby die? She had wanted a baby of her own, but wouldn't it be just as well if they both died? It would mean two mouths less to feed, and the children would not be sorry to have her gone. Perhaps John would not care, either! It was a terrifying thought.

It was at this moment that the visiting nurse came into Elsie's life. Dr. Grayson had said that he would ask her to call. Elsie wondered why. She was prepared to be indifferent to the nurse, to the physical examination and any advice the nurse might give. She was not prepared, however, to be indifferent to the nurse's personality.

The door had no sooner closed behind the blue-clad figure than Elsie Clark was looking at the calendar to see what date the following Wednesday would be. It was just possible that she would accept the nurse's invitation to attend the class for expectant mothers at the district office next Wednesday afternoon.

She did attend class, and saw a nurse demonstrate the correct way to bathe a tiny baby. The nurse made it seem very easy. Would she find it so easy when her time came to do it?

Every Wednesday afternoon after that for the next four weeks she went downtown for the class. She learned what foods would best nourish her and the baby, what preparations she must make for delivery, and how she could make clothes for the baby most cheaply. She liked the classes. She liked talking with women who were facing situations very similar to hers. The classes gave her courage.

On the sixth Wednesday the class missed Elsie Clark. She was too faint to get up from bed. It was the same the next day, and on Friday she was so

*This story received third prize in the recent Case Story Contest conducted by this magazine. See December, 1932, p. 652, and January, 1933, p. 11.

much worse that she finally asked Christine if she would call at the nurse's office and ask Miss Hall to come up. She had expected Christine to refuse or complain, but the girl went immediately with what Elsie almost believed was an anxious expression on her face.

The nurse came that afternoon. It was encouraging to see her again.

What was Mrs. Clark eating?

Very little of anything, the nurse discovered. Why? Elsie had no appetite, in the first place, and then—this was reluctantly told—there was little enough food for everybody. Their money had gone four weeks ago, and ever since John had been borrowing small sums from acquaintances here and there. Lately everybody they knew was too hard up to lend any more. Things were not very hopeful.

Had they thought of applying for aid?

No—Elsie was sure that they never would do that! John and she were not so down and out as that. They would manage somehow.

The nurse explained how many families of their class had been forced to ask for aid in the same way. There was no disgrace in it. Any one in these days might be a victim of the same circumstances. Besides, Elsie owed it to her baby to see that she did not starve herself.

Mrs. Clark agreed to discuss the question with her husband and, in the meanwhile, Miss Hall would get in touch with Dr. Grayson. If John refused to consider taking aid, then Miss Hall would talk it over with him.

So that night when John came home from his daily search for work, Elsie drew him into the bedroom and told him what the nurse had said. He listened without showing emotion, but refused to consider the suggestion.

"We haven't come to that yet, Elsie. We'll manage somehow. I guess I can still support my family. If I could only get a break! Business conditions are looking better."

He did agree, however, to stay home the next morning to talk with Miss Hall.

Miss Hall made him see many things in a different light.

Did he realize his children were malnourished and that malnourishment in growing children was very serious? A child grows up but once and what he loses now can never be made up. Did he want them to be deficient men and women? Furthermore, did he realize that he himself, worn with worry and the uncertainty of where the next cent was to come from, was losing that good nature which had endeared him to his wife and children? Most of all, did he realize his wife was starving herself so that he and the children might have that much more to eat—that she might die if he persisted in cutting her off from food this way?

It was strong language, but John Clark understood it. He was silent for a full minute before he gave his reply.

"How shall I go about applying for aid, Miss Hall?"

. . . . . .

They were granted aid, for they were just such a family as private relief agencies are anxious to help. Both Mr. and Mrs. Clark worked out a weekly grocery order and daily menus with the nurse. Every penny must count toward building up their health.

Mr. Clark became the family bookkeeper, with Jo assisting. It was Christine's part to check the grocery order carefully when it came each Wednesday, and Chester put the articles away in the closet. Wednesday took upon itself a holiday atmosphere. It was fun. The budget was unruly at first, but after a few weeks it balanced faithfully.

Milk was their greatest problem. They could not understand why Miss Hall should insist upon so much milk. They were not particularly fond of it—in fact, Jo would not drink it at all—so why should they not use the money for something else that they liked better?

"I'm afraid you just can't substitute anything else for milk," Miss Hall replied. "It's what we all need most—especially you children who are growing. It's the best body-builder we know."

With the new feeling of coöperation

that had come to the Clark family, Elsie and her step-children grew closer together. But there was still some resentment about the coming of the new baby.

Elsie spoke to the nurse one day about this.

"Why not talk to them about the baby, Mrs. Clark? After all, you can't blame them for feeling left out of the picture, can you? I think I'd feel the same way if I were in their place, wouldn't you?"

But how to go about telling them?

"I didn't think children their age even knew about babies, Miss Hall."

They were to talk it over simply and directly. There was literature that would help Mrs. Clark in her task.

It was difficult for Elsie Clark to tell that story. The children would not meet her eyes, but of that she was glad. It seemed easier if they didn't. They were restless. Yet several days later, Chester, who was taking a course in manual training at school, announced that he would make a table for the baby's tray and some other things.

"Dad's already building a cradle or else I'd do that," he added to Elsie, looking out of the window the while.

Neither cradle nor table was ready, however, for the baby came too soon. For a long while it looked as though they would never be needed. John Clark gave up work on the cradle altogether. Elsie's life might be ending. It would be all his fault. There was no time for cradles then.

With the end of December, however, all doubt was gone. Both Elsie and the new baby were staying with the Clarks.

. . . . . .

There are moments when life throws off its burden—and such a moment had come to the Clark household.

SOME OF THE ADVANTAGES OF THE COUNTY HEALTH DEPARTMENT

The unit of population and wealth is sufficiently large to permit the employment of trained personnel.

One responsible board will be substituted for the many town and village boards of health, and for the county nursing committee, county milk-inspection committee, county school-hygiene committee, and boards of managers of county general hospitals and county laboratories.

A plan of continuing health service can be developed for the whole county and all of the health personnel can be mobilized to meet emergency conditions in any part of the county.

Present duplication and overlapping of effort will be prevented and better health protection can be furnished for present expenditures.

A generalized public health nursing service can be provided under competent supervision.

School nursing activities now lacking in many rural schools can be furnished.

If school medical inspection is made a function of county boards of health, this important activity can be conducted more efficiently on a county-wide basis with trained personnel than under the present system.

Treatment facilities for the control of the venereal diseases can be provided.

The sanitary quality of milk can be assured through a country-wide inspection service.

The sanitary quality of water supplies can be supervised through a county sanitary engineer.

Modern epidemiological methods can be applied for control of the communicable diseases in place of the present ineffective system.—*The Survey, June, 1932.*

Public Health Nursing Service

A Taxpayer's Point of View

By ESTHER L. HILL

THE Public Health Nursing Service now has the most hearty approval and support of the people in our community. Our county (Seward, Kansas) has a population of about 8,000 people, 5,000 living in Liberal, the county seat, and the rest scattered throughout the rural school districts.

Because we lived in an open prairie country with access to sunshine, fresh air, pure water, and an abundance of home-grown, wholesome food, most people felt satisfied with health conditions as they were and believed that we had no need of a public health nurse.

A few public-spirited persons who were close observers of conditions in our public schools, realized, however, that there were children who were handicapped in their school work, and in life in general, who could be helped if it were some one's particular responsibility. If teachers, neighbors, or clubwomen tried to advise parents along these lines, they were regarded as meddlers and accomplished nothing.

Through the earnest efforts of the County Chapter of the American Red Cross, a Public Health Nursing Service was established as a county-wide project, ten years ago last August. A wide-awake Red Cross public health nurse was secured at a salary of one hundred and fifty dollars per month the year around.

The financial side of this project alone makes an interesting story. During the first few years, while the public was being educated as to the value of the nursing service, the Red Cross maintained an office for the nurse and paid her salary. As the various bodies became familiar with the work and realized the value of such a service they were willing to share the expense. During part of the time the county commissioners, the city council and the city school board each paid one-third of the salary. At the present time the county commissioners and the city school board each pay half. The salary is now two hundred dollars.

If there were no other advantages than the financial saving alone, not one of these organizations would consider dispensing with the nursing service.

PREVENTS EPIDEMICS

Before we had the Public Health Nursing Service our schools were closed every winter because of contagious disease, sometimes for only a few days but sometimes for weeks at a time. Since we have had the service the schools have never been closed for a single day and at no time has there been even a near epidemic. That alone means a saving of thousands of dollars because it costs between four and five hundred dollars a day to run our schools, and most of the expense goes on just the same while they are closed during an epidemic.

Another saving is effected by maintaining a better average attendance. The daily inspection of the pupils in the city school when there is any chance of contagion makes it possible for the nurse to detect the symptoms before the disease has developed to any great extent. The child can be taken home and treatment started, which often prevents a long absence from school and avoids exposing other children to the disease.

The first thing that we did when we inaugurated the public health nursing program was to organize a nursing committee. The chairman of the nursing committee was appointed by the Red Cross. The other members were: one from the city council, one from the board of county commissioners, the county school superintendent, and the city school superintendent. This committee with the nurse plans the general

health program. It assists the nurse in every way possible, advising and backing her in her work, and acts for the community in selecting and engaging a new nurse when it is necessary to make a change.

MEDICAL COOPERATION

At the very beginning of our project we secured the coöperation of our county doctor and of all the other physicians in our town. With their assistance and the help of members of the various Parent-Teacher Associations acting as clerks and general assistants, we started our health work with a school clinic, in which every child from the beginner to the senior in high school, both in town and in rural schools, was weighed and measured, his eyes, ears, nose, throat, teeth, and general physical condition examined and a record made on individual cards. The parents were sent copies of these cards and in case defects were found and checked on the card the parents were asked to consult their family doctor. As corrections were made they were reported to the nurse and marked on the card. All of these cards are kept on file in the nurse's office and give her a complete health record covering the last ten years of life of every child in the county.

These clinics have been held every year at the beginning of the school term and in May the preschool clinic is held. The clinics are held in every school in the county and have done much to interest both the child and his parents in better personal health and also in better health conditions in the community.

The parents are always asked to attend the clinics and many become interested in asking questions not only in connection with the child in the clinic but about the health and care of other members of the family, especially babies and aged persons.

The sanitary condition of the school buildings and other public places is looked after, too, as the nurse's inspection extends to the drinking fountains, toilets, rest rooms and cloak rooms of all such places.

In the summer when the nurse is not so busy with the school program we have regular classes in "Home Nursing and Care of the Sick." These are taught by the nurse in accordance with the textbook put out by the American Red Cross. Enrolled in these classes are mothers, high school girls and business women, who find this instruction very valuable in its application in the home.

Every club and society in the county is glad to have the nurse speak at its meetings, thus keeping us posted as to the health conditions and needs of the community. Most of the organizations have contributed freely to pay for needed corrections among poor children and have helped in caring for the crippled.

EVERY CRIPPLE UNDER SUPERVISION

Through the efforts of the nursing service we have located every crippled child in the county. Since our nurse is very progressive, she has been able to advise the parents of these crippled children in regard to each individual case and has urged that they be taken to specialists for examination and advice. As a result of her efforts practically every crippled child in this county has been cared for. Many of them would never have been helped, because the parents had not the correct information nor the funds with which to have necessary treatment given. Many of these children are completely cured and are now in school, looking forward to lives of usefulness, both to themselves and to the community. This alone is worth more than the expense of the nursing service.

Our nurse is known and loved by every boy and girl in the county and nothing pleases the children more than to stop her on the street with "Oh, Miss ——, see where I hurt my hand. Should I go to the doctor?" or "Say, will you pick out this splinter, Mother hurts so." The nurse knows every child by name and never fails to greet him. One of the strong incentives for the children of our careless families to keep themselves neat and clean is that they may win the

approval of the public health nurse when they meet her on the street.

The nursing service and the relief work go hand-in-hand. The nurse has a place on the relief committee and her services are very valuable.

Our public health nurse, garbed in her immaculate uniform with spotless white collar and cuffs, carrying her little black leather bag, is a picture of health and is surely good to look at as she goes in and out of our homes, public buildings, and hurries about our streets. She gives us a feeling of security that we did not have before we had the public health nursing service.

Itinerant Nursing Service in Illinois

By RUTH HENDRICKSON, R.N.

WHEN the Illinois Tuberculosis Association started an itinerant nursing service two years ago, it had two objectives in mind: to give virgin territories a short-time demonstration service paid for by local Christmas Seal funds, with the hope that the county itself would establish a public health service; and to start the development of a school health program that would create a permanent interest among parents, teachers, children, and school boards.

If the first objective could be accomplished, the second would be easy. But we needed a working basis that would provide some foundation for meeting the needs and understanding the possibilities of the territory.

It was decided that of first importance upon entering any new territory was the discussion of the entire purpose and plan of the service with all organizations and school authorities. This would promote community interest.

Washington County was the first county in Illinois to request the itinerant nursing service. Our plan of procedure was followed with one exception: Since there were no county medical or dental societies it was necessary to meet the physicians and dentists individually and secure the assistance of each in approving the work in his particular community. The entire program was discussed also with the County Superintendent of Schools and with the Superintendent of Schools in each town.

The program in this county was entirely educational. Much time was spent with teacher groups where demonstrations of hot lunch, hand washing, and health correlation lessons were given. The nurse's school visits consisted of health talks, stories and demonstrations to the teacher of health lessons in the school room.

In a virgin territory where only a short-time service is given, one must present a definite plan. This plan must be so arranged as to retain the interest after the nurse has retired from the field; to develop healthy attitudes for health in the community, and to secure the interest of every individual.

With this in mind a survey of school health conditions was developed and a contest program carried out in the rural schools as a means of developing the child's and teacher's originality.

In 1932, Cass County started a four months' itinerant nursing service in the schools. The primary objective of the committee was to make a survey of the physical status of the school children. However, the County Superintendent and chairman of the committee felt that such a survey made by a nurse was of little value in itself and dangerous without some preliminary educational work, especially in the one-room school. They also felt that such a plan was limited in its objective.

A plan was worked out, therefore, to establish a motivating school health program with the following objectives:

1. To make a survey of the physical status of the school children.
2. To bring all schools within reach of normal healthy living conditions.
   A. Lower grades—
      a. To establish health ideals and health attitudes.
      b. To provide practical information regarding principles of healthy living.
      c. To provide information on how to practice these habits.
      d. To establish good health habits.
   B. Upper grades and high school—
      a. To develop health ideals and attitudes.
      b. To broaden the student's knowledge about the most worthwhile things in life.

The contributing factors toward the success of any such procedure necessarily included the interest and coöperation of the County Superintendent of Schools, school boards, and teachers, as well as the parents and children.

The County Superintendent called a meeting of all rural teachers, at which time the plans were explained and an outline handed to each teacher. The outline contained:

1. The objectives of a school health program.
2. Points of consideration in its development:
   A. School environment—
      a. The explanation of the physical survey.
      b. The morning inspection.
      c. The weekly clean-up.
      d. Paper cups or fountain, and paper towels.
      e. The First Aid Kit.
      f. Ventilation.
   B. Children's practices—
      a. Washing hands under running water before lunch.
      b. Use of individual combs.
      c. Assisting in morning inspection.
      d. Assisting in weekly clean-up.
   C. Home and school activities—
      a. Fifty per cent of children with teeth in perfect condition.
      b. Water tested and found satisfactory.

These various items for consideration were listed with different values approved by the County Superintendent. Those reaching the one hundred point goal were called "Grade A Health Schools," while those attaining eighty points were called "Grade B." It was realized that many schools could not attain this goal within the four months and in this way were left with some working basis for the coming term.

Demonstrations were given at this meeting on how to serve a hot lunch at school without cooking or dishwashing. The technique of preparation, responsibility for serving, methods of securing proper kinds of foods were taken up in this demonstration. The hand washing demonstration was given showing how fifty teachers might wash their hands in a sanitary way in less than ten minutes. A demonstration of a first aid kit was also given. Suggestions for securing the coöperation of the parents and children were discussed in this meeting.

The purpose and plan of the nurse's visit to the school was explained to the teacher. This included a get-acquainted talk to the children, leading to the organization of a health club in the school. The officers of the health committee served as health inspectors of the school, assisted by the teacher. New officers were elected each term, thus allowing more children to participate.

The second visit was for the purpose of making the physical survey. However, previous to this visit, the nurse interviewed each physician and dentist in the given community and secured his assistance in the procedure. Whatever findings the nurse made were not listed as defects, but such information as seemed valuable to the parent was translated by the teacher or school superintendent. Many parents were interested in attending school the days of the nurse's, physician's, and dentist's visits.

Due to the short period of time, many calls upon the nurse to attend health programs and community meetings had to be refused.

In two communities dental inspections were made by the dentist and several others expressed their desire for this service another year. The dental inspections revealed approximately 97 per cent of the mouths in poor condition in Cass County. During the second visit a demonstration on the brushing of teeth was given, as this appeared to be a good

opportunity to drive home a health idea. In one school, one room had a first grade boy with perfect teeth. The teacher seized upon this opportunity to develop by every possible teaching device a desire for clean mouths. The nurse made an inspection of this room at the end of the four months and found one hundred per cent of the children with clean mouths. This same interest was displayed by all teachers and children regarding the entire program.

Both school visits were made in a rather leisurely fashion and both proved to be fascinating and full of interest. The second visit naturally revealed more friendliness and more items of common interest. The children were not embarrassed in the least, were eager to tell of their health activities, and quite ready to take part in the events of the day. Frequently, the children had prepared a song, a reading, or a program for the second visit.

Hand washing under running water before lunch was popular in forty-nine schools. This procedure has proved increasingly popular in both Washington and Cass Counties. Teachers secured many kinds of home-made equipment to foster this habit. Liquid or powdered soap was used and at the end of four months the slogan was "Bury the old cake of soap and wash pan."

Some form of hot lunch was developed in forty-four schools in Cass County. Some schools were fortunate in having the parents take turns in bringing a fully cooked dinner to school at noon. The writer attended a few such dinners and was at all times assured of a hot lunch during the cold days of visiting schools! Not only did the hot lunch build up the physical fitness of the children, but gave opportunity to develop friendships, interesting conversation, and consideration for one another.

Nine schools secured either paper drinking cups or bubbling fountains and many more are planning to have this equipment the coming year. Here, too, home-made equipment came into use. One school board made a fountain by attaching a pipe to the pump with bored holes alongside. One person pumped and each had a clean drink of water. The State Department of Public Health assisted the teachers by testing the water for each school that sent a specimen. The remarks and advice sent back to the school were followed by the school boards in most cases. This work was done by the school health committee.

The growth of interest among the teachers and children was evidenced in the surprising number of schools adopting the demonstrations outlined, the pleasant atmosphere of the school room, and the eagerness of the children and parents to take part in the physical survey. It is indeed unfortunate that lack of funds has forced the abandonment of this itinerant nursing service for the time being.

The Public Health Nurse and the Community Social Hygiene Program

By GLADYS L. CRAIN, R.N.

Assistant Director, National Organization for Public Health Nursing

PUBLIC health nursing, whatever else it may be, is a community service which has developed in response to real needs.

Therefore, its continued growth depends upon the ability of its members to adapt themselves to changing conditions, to interpret trends, and to meet new conceptions of community health promotion with foresight and intelligence. Whatever contribution the public health nurse gives to her community must enrich, or add to, but not duplicate what is already being done for the welfare of individuals and families. This does not mean that her program is a restricted one, for through coöperative relationships, a keen awareness of lacks, and an ability to stimulate the development of better community health facilities she greatly extends her influence and usefulness.

During the past few years social hygiene activities, especially as they relate to the control of syphilis and gonococcal infections, have been gaining recognition as major public health concerns. Signs of the times point to an aroused interest among a variety of health and social workers, probation officers, and other professional and lay groups who are earnestly studying methods for controlling the disease and the abolishment of environmental influences which encourage their spread.

Public health nurses are not lagging behind in this movement, for by means of study programs, staff education and extension courses, they are preparing to meet this new challenge. It is obvious that education in the medical and nursing facts of the diseases, syphilis and gonorrhea, is a necessary prerequisite for intelligent participation in a community social hygiene program, but this is not enough. Knowledge of what has been accepted as a workable community program for the control of these diseases is quite as important; also what is actually being done in the community to which the nurse belongs, what is left undone, and what part of this program is basically a public health nursing job. In order to build her service upon a solid rock of fundamental needs, a careful survey of resources should be made.

Present community programs in the field of social hygiene have their common origin in the "American Plan" which was evolved during the World War, to control the spread of syphilis and gonorrhea in the army. This threefold plan included:

Education of the soldiers regarding the venereal diseases, their prevention and cure; also education in a saner approach to sex.

Control of prostitution, the eradication of other vicious environmental influences, and the establishment of wholesome recreational facilities.

The setting up of clinics for diagnosis and treatment of infected individuals, and the teaching of prophylactic measures.

The phenomenal success of this program in reducing the number of cases of venereal disease in the army resulted in the adoption of a modification of these measures by civil communities. This movement was furthered by the Chamberlain-Kahn Act which made it possible for the Federal Government to subsidize states in order that bureaus for the control of the venereal diseases might be established and maintained. This subsidy was available from 1919 to 1921.

Today most communities have developed a program which embodies the three elements considered basic to a successful combating of syphilis and gonorrhea. These measures are:

Medical measures which are the first line of defense and include epidemiological practice (reporting of all cases, search for sources of infection and examination of contacts), diagnostic service in state and local laboratories; and hospital and clinic facilities for treatment of infected individuals.

Legal measures which include laws and ordinances for the suppression of prostitution and for quarantining infectious and recalcitrant patients.

Educational measures for teaching the public the nature of the diseases, syphilis and gonorrhea, the importance of preventive measures, early diagnosis and adequate treatment; the promotion of sex character education for children and the training of parents, teachers, etc., for the task.

No local agency is carrying the entire burden of this complicated program. It is a community enterprise in which both official and non-official groups have a share. The ultimate responsibility for the control of disease and the protection of the health of the community rests with the health department. The health officer should be looked to as a leader and his approval sought in all projects which private agencies, in this field, are contemplating. Also, they should adopt such standards as will conform to the requirements of the local sanitary code.

The following questions summarize some of the major activities in a community social hygiene program. It goes without saying that rural areas and small towns will not have as many of these resources as the larger cities, but the state or county often is prepared to give far more assistance in the solution of social hygiene problems than local groups are aware of.

I. *Medical measures in your community*

A. The Health Department:

1. Is there a bureau or division for venereal disease control?
2. If not, how is this public health problem handled?
3. Is there provision for epidemiological investigations? Are nurses employed in this field?
4. Is there an official diagnostic laboratory?
5. What are the provisions for the treatment of indigent patients in the city? In rural areas?
6. Is the reporting of cases of syphilis and gonorrhea enforced?
7. How many cases were reported last year?
8. What is the content of the sanitary code?
9. Does the health department maintain its own clinics or subsidize hospital and private clinics for the treatment of syphilis and gonorrhea?
10. How are lapsed cases and recalcitrant patients handled? How does a knowledge of these facts assist the nurse in her own program and the solution of individual problems?

B. Private clinics attached to hospitals or dispensaries:

1. How many treat syphilis? Gonorrhea?
2. On what days are clinics held? Are there evening clinics?
3. Standards:
   - *a.* Methods, diagnosis, and treatment.
   - *b.* Case holding, investigation of sources of infection, attention to contacts, lapsed cases.
   - *c.* What percentage of cases remains under treatment until cured?
   - *d.* Constructive teaching in clinics.
   - *e.* Program for the detection of syphilis in pregnancy and the prevention of congenital syphilis.
   - *f.* Program for patients with gonorrhea, especially prenatals and children with gonorrheal vaginitis.
   - *g.* Is there social service follow-up?
   - *h.* Is there nursing follow-up?
   - *i.* What coöperative arrangements have been worked out with public health nursing groups? If there are none, is there a field for service here?

C. Private Physicians:

Are they treating syphilis and gonorrhea? What plans have they for case holding? Examination of contacts? Sources of infection and lapsed cases?

Is there a field for public health nursing service in the follow-up of private physicians' cases?

D. Public Health Nursing Groups (School nurses, industrial nurses, health department nurses, visiting nurses, etc.):

1. What are these groups contributing in the way of follow-up, case finding, family health teaching, the prevention of congenital syphilis, work with gonorrheal vaginitis cases including individual and group teaching of adults, etc.? What coöperative relationships have been established to coördinate the work done in this field?

II. *Legal protective and recreational measures*

A. What are the laws regarding the control of infectious individuals, food handlers, reporting of cases, etc.? Regarding interstate travel of infectious patients?

B. Laws for controlling prostitution and other vicious elements in the environment.
C. Court and health department activities in this field.
D. Work of policewomen and probation officers, etc.
1. What is being done for young sex offenders in the way of rehabilitation?
E. Are there citizens' committees active in this field?
F. Are parks, playgrounds, dance halls, and other places of amusement supervised?
G. What provisions for wholesome recreation are found in churches, clubs, settlements, Y.W.C.A. and Y.M.C.A.'s, Boy Scout organizations, etc.

III. *Educational measures*
A. Health Department: Are there pamphlets, films, exhibits, lectures, etc., available here?
B. Libraries: Is this a source for books and articles on social hygiene?
C. Social hygiene societies: What can be obtained in the way of books and pamphlets, speakers for clubs, etc.? Is there a consultation service?
D. Schools: Is sex education integrated in the school curricula?
E. Churches and other character-building organizations:
1. What is being done to guide boy and girl relationships?
2 Are women's clubs, parents' organizations, etc., studying sex education problems?

Although the public health nurse must have an intelligent grasp of the broad aspects of a social hygiene program, and the types of agencies participating in these phases, her chief concern will be in the realm of communicable disease control, and she will coöperate most closely with institutions dealing with the problems which complicate this activity.

Most nursing organizations where a social hygiene program has been established have set up the following objectives:

1. To assist in finding all cases of syphilis and gonorrhea and all contacts.

2. To assist in arranging for medical supervision, early diagnosis treatment and follow-up.

3. To assist in securing complete reporting of all cases.

4. To secure nursing care and supervision in the home.

5. To assist in giving constructive individual and family health teaching.

The emphasis, however, has been different depending upon community needs and resources.

The following are a few of the actual services which public health nursing organizations are giving in the field of social hygiene:

I. A complete follow-up service for all cases of syphilis and gonorrhea attending public venereal disease clinics.

II. A follow-up service in connection with private clinics for all cases of syphilis and gonorrhea presenting a family health or nursing problem. Such cases would include all congenital syphilitics, all cases where there are children in the family, all cases of gonorrheal vaginitis, all cases where there are dressings, treatments, or bedside care. This type of coöperative project usually supplements the work of the social service worker who handles complicated social situations, etc.

III. A service in connection with an existing prenatal program, emphasis being placed upon the prevention of congenital syphilis. Early examinations, routine Wassermann tests, close supervision, attention to all contacts when syphilis is present in the mother, and special planning for the new-born baby are a few of the activities here. This involves coöperative planning with prenatal clinics, reports on Wassermann findings, progress of treatment, complications, etc.

IV. A follow-up service for private physicians' cases.

V. A service recently under consideration in a private organization involved a small group of syphilitic families. These were selected for the purpose of studying content and method of health teaching most effective with this group, number of visits necessary, reasons for lapses in treatment, care of contacts, and the complicating health and social problems which present obstacles to treatment and cure and prevent a complete adjustment of the family.

In studying community programs for the control of syphilis and gonorrhea, it is evident that the least developed services are those which might be listed under family health and prevention. The major emphasis, in many places, is still upon mass treatment of individuals. Public health nurses are especially equipped to assist in filling this serious gap. In these times of economic insecurity, new services cannot be developed but the existing program can be enriched.

A generalized nursing service provides ample opportunity for case finding and family teaching through its prenatal and child welfare programs alone.

The industrial nurse has an opportunity to do preventive work if she has developed a sensitiveness to symptoms which deviate from the normal and may mean a syphilitic or gonococcal infection, through advice regarding the importance of physical examinations and other health teaching.

The school nurse may also contribute to the program through case finding and arranging for home supervision of congenital syphilitics.

The rural nurse has a challenging task, along with all the others mentioned, of stimulating the development of adequate treatment facilities by presenting striking situations which show the need.

Whatever coöperative services are developed in public health nursing organizations, it is necessary to consider them from the standpoint of benefit to the agencies concerned, and to the community, and their value in developing a more satisfactory service to patients and their families. In summing up her chapter on venereal disease work in her textbook, "Public Health Nursing," Miss Mary S. Gardner presents a challenge worth considering, which we quote:

"Nursing has a wonderful tradition which has come down to it through the ages, that wherever human suffering exists, there it is a nurse's privilege to be. Perhaps that privilege can be no better exercised than in ministering to a class of patients whose physical suffering is augmented by the fact that a stigma is attached to the disease which attacked them. By this ministry a nurse may gain a personal understanding that will perhaps help her to do her part in bringing the venereal diseases out of their present hiding places into the full light of day, where they may be fought and vanquished as have so many other scourges of mankind."

QUESTIONS FOR DISCUSSION

1. What has been accomplished in your community in social hygiene? (Summary of resources)
2. What are the gaps in the community program as you see it?
3. What particular contributions can your organization make in the light of these facts? What might your personal contribution be?
4. What is your organization doing in this field at the present time? (Summarize activities)
5. What are the next steps to take?

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Public Health Nursing and Social Work in the Town and Communes of Brussels

Editorial Note: The Congress of the International Council of Nurses is only five months away! We are publishing this month some public health nursing information which may be useful to those who visit Paris and Brussels in July.

BRUSSELLS is composed of eighteen communes (faubourgs) which are all autonomous—each possessing its own administration, health organization, schools, police, etc. From this fact arises the great multiplicity of public services in Brussels, and specialized service carried to excess. It might be well to draw attention to the generalized service attempted in two communes, Uccle and Jette: the latter has been particularly successful in the creation of a Health Center where all the activities of public health nurses are concentrated. On the initiative of the Red Cross, the commune of Boisfort has just opened a new Center which gives every promise of being a model of its kind.

The Red Cross itself possesses a Health Center situated in the Place Georges Brugmann, in a building dedicated to the memory of its former President, Dr. Antoine Depage, where the separate and autonomous departments, whether occupied in Child Welfare, Tuberculosis, Mental Hygiene, or other services, collaborate in a successful manner. We would specially recommend a visit being paid to the outstanding Mental Hygiene department.

The commune of Schaerbeek has a school clinic at Avenue Louis Bertrand, which has been in existence for twelve years. The service is free and the public health nurses also look after infants in their homes. This commune also has a number of other institutions dealing with public health, for instance, swimming baths, sports field, open air schools at the seaside, etc.

To those interested in child welfare work, we would strongly recommend a visit to the offices of the Oeuvre Nationale de l'Enfance, 67, Avenue de la Toison d'Or, whose activities are extended over the entire country—consultations for infants, care of premature babies, crêches, permanent open-air schools, maternal homes, institutions for convalescent or abnormal children, etc. Three hundred public health nurses are attached to these various services.

The Anti-Tuberculosis League possesses a few dispensaries at Brussels as well as sanatoria both in the country and at the seaside.

The protection and instruction of the mentally deficient is carried out with much care in Brussels. The late Dr. Decroly, whose name is associated with his efforts for these unfortunate individuals, was particularly interested in this work. The institutions at Rixensart, Bierbaix, and the Farm School of Waterloo are well worth a visit, and those interested in the teaching of the deaf-dumb and the blind should visit the Royal Institute, rue Rempart des Moines, directed by the unusually efficient and devoted Sisters of Charity of Gand.

The School of Public Health Nursing in Brussels

The School of Public Health Nursing in Brussels was founded in 1919 by the Association of Public Health Nurses of Belgium. On October 1, 1932, it was taken over by the Poor Law Relief Board of Brussels.

Formerly the School had a three-year course of study, two years of which were devoted to the general course of training and the third to specialization in public health nursing. During its thirteen years of existence, it has graduated 183

students. At present it is giving only a course of specialization. The School is situated at 33, rue Caroly, where it will remain until the completion of St. Peter's Hospital.

The course of instruction lasts a year. The candidates admitted must be in possession of the State diploma of a hospital nurse, or have completed a two years' course of training in a recognized school of nursing.

The curriculum includes, in addition to those subjects mentioned in the Royal Decree of September 3, 1921, the following: Industrial Hygiene, Mental Hygiene, Prison Anthropology, Elements of Civil and Administration Legislation, Organization of Poor Relief, Social Case Work, History of Nursing. Students must submit written and oral reports, attend class-work, conferences and practical demonstrations in taking care of the patients in their homes as well as First Aid Work. They obtain their practical experience during a period of ten months in different public health and welfare organizations in Brussels. Students who successfully pass the final examination obtain the State Diploma in Public Health Nursing.

The School, which is undergoing certain transformations, has at present only twelve students in the third year of training. When it is finally installed in the University Hospital of St. Peter, it will be able to accommodate twenty-five students.

The staff includes a Director (a nurse) and a Nurse-Instructor responsible for the management, instruction, and supervision of the courses.

The cost of the course is 3,750 francs. Scholarships may be awarded to students who promise to remain in the service of the Poor Relief of Brussels for a period of at least two years after the completion of their course. Each student receives an allowance of 150 francs per month to cover daily fares.

The Association has organized a visiting service for the lower middle class. It is carried out by 11 public health nurses who care for those who request their services and also look after a great number of families presenting special problems: invalids, orphans, war victims, unemployed, etc. The 15,119 visits made during the year 1931 are a striking proof of the activities of the public health nurses.

The School of Midwifery of the "Grand Maternite" of Paris

It was over a century ago that the Minister Chaptal conceived the idea of founding a large school of midwifery with the aim of recruiting and training the midwives for all France. On July 28, 1802, he sent circulars to the prefects announcing the opening, in connection with the Maternity Hospital in Paris, of a school for the theory and practice of midwifery, which would admit students either at their own expense or at the expense of the government.

For 130 years this school has been sending out trained midwives to all sections of the country. Students for the course, which is two years in length, are accepted once a year on July 1. Both the entrance requirements and the curriculum are regulated by ministerial decrees.

The instruction in the school includes: theory and practice of midwifery; vaccination; blood-letting; and elementary chemistry dealing mainly with the antiseptics used at confinements. Throughout the two years the instructors may give examinations, after which any students who are considered unfit or incapable of continuing the course may be dropped. After the final examinations at the end of the two years, each student receives from the Director of the Hospital, upon payment of 25 francs, a diploma of midwifery of the first class, with permission to practice in any part of France.

INTERNATIONAL CONGRESS OF NURSES

The Chairman of the American Nurses' Association Transportation Committee, Miss Florence Johnson, announces that all transportation matters in connection with the International Congress of Nurses in Paris and Brussels, July 10 to 15, 1933, have been completed by the Official Travel Agents, Thos. Cook & Son-Wagons-Lits, Inc.

An illustrated booklet containing detailed information about steamship sailings and rates, tour itineraries and all-inclusive fares, daily program of events, etc., is now available and copies may be secured from Miss Johnson, District and State Chairmen, or any one of the several offices of the Official Travel Agents.

An announcement of special interest is the concession made by the major transatlantic steamship companies, in coöperation with Cook-Wagons-Lits, to allow all who were members of the American Nurses' Association prior to December 1, 1932, to book at the low rates which were in force prior to December 5, 1932. On that date, all transatlantic fares were increased from 6 to 12 per cent, but as arrangements in behalf of the A.N.A. members had already been made, it will mean a very considerable saving in transportation costs.

It is assumed that most of those in attendance from America will sail about the first of July in order to arrive in Paris shortly before the Congress opens. There will be plenty of time for post-Congress travel in Europe before the height of westbound travel across the Atlantic. From June 27 to July 1 there are a dozen ships of various lines sailing from New York to French ports, arriving from July 4th to the 9th. The descriptive booklet contains the details of these sailings and the fares in first, cabin, tourist, and third classes.

Round trip transatlantic fares (as of December 1, *i. e.*, prior to the increases) for various classes from New York to a French port are as follows:

First	$236 to $416	(minimums according to size and speed of ships)
Cabin	$211 to $285	
Tourist	$161 to $184	
Third	$123 to $139	

plus U. S. tax of $5 and French port taxes.

Experience at similar congresses held abroad in past years has proved the value of the escorted tour idea as being the most convenient and economical method of traveling. Anticipating a considerable demand for this type of travel, the Official Agents have arranged a variety of tours which cover a majority of the most popular European routes and which should appeal particularly to A.N.A. members.

There are seven main tours, ranging from 28 to 43 days' duration, and from $257 to $435 all-inclusive fares. Then there are various extension tours for those who can extend their travels farther afield, running up to 60 days' duration and with fares from $357 to $560. All of the inclusive fares are extremely low, especially considering the standard of comfort provided and their all-inclusive nature. An experienced tour manager from the staff of Thos. Cook & Son-Wagons-Lits, Inc., will accompany each group to look after all travel details, thus enabling individual members to make the most of their time abroad and thoroughly enjoy every moment. The descriptive booklet contains complete details of all of the tours.

CONTRIBUTORS PAGE

W. W. BAUER, B.S., University of Wisconsin; M.D., University of Pennsylvania. Dr. Bauer served in the United States Army Medical Corps at base hospitals and Camp Grant, Rockford, Illinois. He carried on private practice in Milwaukee, Wisconsin, and Canyon County, Idaho, 1919-1922; was epidemiologist for the Milwaukee Health Department, 1922-1923; Commissioner of Health, Racine, Wisconsin, 1923-1931; and Director, Bureau of Health and Public Instruction, American Medical Association—his present position.

LESLIE WENTZEL, R.N., is a graduate of the Presbyterian Hospital of Philadelphia. She holds a B.S. degree from Teachers College, Columbia University. She has been Superintendent of the Scranton Visiting Nurse Association for the past ten years. She was formerly State Supervisor of Pennsylvania under the American Red Cross, has carried on public health nursing in Scutari, Albania, and been Director of Field Work of the Public Health Course in Rome, Italy. She was in the Army Nurse Corps during the World War.

MIRIAM AMES, R.N., whose report of the Chicago Hourly Appointment Service is summarized here, was executive director of the Service throughout its experimental period—through July, 1932. She was formerly assistant director of the Nursing Service of the John Hancock Mutual Life Insurance Company. At present, Miss Ames is studying at Teachers College, Columbia University.

LILLIAN R. SMITH, M.D., in addition to being the Director of the Bureau of Child Hygiene and Public Health Nursing of the Michigan State Department of Health, is Director of the Summer Round-up of the Children, National Congress of Parents and Teachers.

EDITH E. McCARTHY, the winner of third prize in our Case Story Contest, is a graduate of Radcliffe College and at present the publicity secretary of the Boston Community Health Association.

MRS. J. D. HILL is the wife of a retired farmer. She taught school ten years before her marriage and has reared a family of boys to manhood. For the last fourteen years she has been connected with various organizations such as the Red Cross, Parent-Teacher Associations, and civic groups. She writes she has "had the privilege of working for the advantages and improvements in health, the need of which I have felt so keenly while teaching and while my boys were in public school." We believe that Mrs. Hill has been very successful in presenting a convincing argument for the need and value of public health nursing service.

RUTH HENDRICKSON was graduated from Lakeview Hospital, School of Nursing, Danville, Illinois, and studied public health nursing at Peabody College, Nashville, Tennessee. She has been Supervisor of Health Education for the Ford County Public Health Association, Ford County, Illinois, and itinerant nurse for the Illinois Tuberculosis Association for two years. At present she is carrying the county nursing service for Douglas County Tuberculosis Association, Illinois.

"Not for the abundance of its broad acres, nor for its clanging furnaces, nor yet for the magnificent chaos of its cities, will the State at last be known, but for the strength and beauty of its children."

ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

Edited by KATHARINE TUCKER

N.O.P.H.N. STAFF ACTIVITIES

After the many field trips of October and November, the N.O.P.H.N. staff devoted December and January to less extensive and time-consuming activities in the field, with increased attention to desks piled high with correspondence and to office interviews that amounted to field service. In November Miss Haupt retired from the front ranks to have her gall bladder and appendix removed. She returned "as good as new" in January.

Increasing calls from the field both through correspondence and field advisory visits show that agencies and individuals are turning more and more to the N.O.P.H.N. for help in adjusting under the new and ever-changing conditions. It is all the N.O.P.H.N. can do to keep a leap ahead of events and be ready to offer the experience of others to the field as well as the considered decisions of the staff and National committees, whose personnel represents country-wide experience. Indeed, so great has been the pressure during the last few months, that in order to gather this up-to-the-minute material and to respond to requests for assistance, the Executive Committee of the N.O.P.H.N. voted to make a temporary addition to the staff to assist in meeting these exceptional demands. The Organization has been most fortunate in being again able to secure Mrs. Elmira Bears Wickenden to assist in this temporary capacity. Mrs. Wickenden is well known to the N.O.P.H.N. members as she has at two previous times been a member of the staff. Therefore she is already oriented to the organization and also to public health nursing throughout the country, which is a great economy in making her help count immediately with minimum adjustment.

Field activities during December and January consisted chiefly of the following services in New York, New Jersey, Massachusetts, and Pennsylvania: addresses at six annual meetings of local associations; an institute for board members; a conference with a representative group of public health nurses and health officials to consider the whole question of the community needs for public health nursing service in one locality; consultant field service to two corporate agency members, considering how they should adjust to the present situation; a meeting with one large supervisory group; and a talk at an industrial nurses' club. In addition, a tuberculosis institute was conducted by Mrs. Hodgson in Newark, N. J., and Miss Crain, during a two-weeks' period, assisted the Visiting Nurse Association of Buffalo in the integration of social hygiene throughout its services.

The public health nursing course at Fordham University, New York City, has been added to the list of courses approved by the N.O.P.H.N. Education Committee. All but one member of the Education Committee were present at the last meeting of the Committee—representing nine states!

A report of the January Board meetings and the financial report of the N.O.P.H.N. (including magazine) will be published in our March number.

The N.O.P.H.N. Nominating Committee for the 1934 ballot is as follows:

Chairman: Eva F. MacDougall, Director, Division of Public Health Nursing, Indiana State Board of Health.
Alice C. Bagley, Assistant Superintendent of Nursing, Metropolitan Life Insurance Company, San Francisco, Cal.
Gertrude Bowling, Director, Instructive Visiting Nurse Society, Washington, D. C.
Erna Kowalke, Director, Visiting Nurse Association, Milwaukee, Wis.
Ruth Mettinger, Nursing Field Representative, American Red Cross.

BOARD AND COMMITTEE MEMBERS FORUM

Edited by KATHARINE BIGGS MCKINNEY

HOW ONE VISITING NURSE ASSOCIATION PLANNED FOR A POSSIBLE REDUCTION IN ITS BUDGET AND SERVICES

The writer is one of those who believes that nothing in the present economic situation in any way warrants the crippling of public health nursing or other fundamental social services. The sums spent for such purposes are relatively so small and the results obtained so vital that no wise community can afford to reduce them. Furthermore, the writer lives in a community which shares this view and stands ready to make the temporary sacrifices necessary to maintain it. Its Chest budget for 1933 has just been raised with success. Nevertheless, it is always well for us to be prepared for emergencies, and thus avoid "panic thinking."

In New Haven, our association had just decided upon a 10 per cent reduction in salaries. This suggestion came from the nurses themselves, who had considered the matter in conference with all the social workers of the city. We accepted this suggestion with regret since the salaries of nurses in prosperous times were relatively so low that they should now be maintained. We are carrying the original salaries in our records with the statement that the reduction is a concession to a temporary emergency. We have also made a number of minor administrative adjustments, delayed replacement of automobiles and the like. As early as last April we began to consider what further steps we must take for the following year, *if* the community drive were unsuccessful.

As president of the Visiting Nurse Association, I asked the Executive Secretary of the Chest if he anticipated a request to the agencies to cut their budgets for the following year, and, if so, by how much. We got the reply that the Chest would do everything in its power to prevent this step, but that it might be wise for the Visiting Nurse Association to consider what a cut of 10 per cent in budget (if it should prove necessary) would mean translated into terms of service.

The Director of Nurses and a committee of the Board then discussed in general terms what our policies should be in regard to cutting. Where could we cut with least harm to the future health of our community? Should we definitely cut out a service, as for example the delivery service? Should we narrow the scope of our work and do whatever we do perfectly, or should we attempt to serve more superficially a larger number of people? These were some of the questions we considered.

This committee then asked the Director to take back the problem to her supervisors and nurses, to study it from the professional viewpoint and to make alternative suggestions to the Board. Possible changes in a public health nursing program require the technical knowledge of the nurses and are obviously outside of the scope of lay board members.

The nurses collected their data and came back to the Board with a list of suggestions.

The Board and the Director discussed the different propositions and after considering all the implications with equal care, decided to write to the Chest urging the importance of maintaining the present budget, but stating that if the Chest drive should prove unsuccessful, a decrease in the budget of the Visiting Nurse Association would mean withdrawing from the community certain definite services, specified in some detail and in order of importance.

None of these reductions was actually required, thanks to the success of our

Drive, but we were prepared for the situation if it had arisen. The kind of reductions would, of course, differ in different localities, but we believe our general method of approach has wide application.

We believe that the problem of cutting services within a reduced budget is always a decision to be reached by both board and staff, thinking and deciding together. The technical changes in a program can be suggested only by the nurses. What would any change mean? Only the nurses understand what a rearrangement of a service here would mean to a service there.

The Board, having made its decision, must then explain its action to the community—that is, give it strategic publicity. We must be sure that the public understands that the action results from enforced economy and knows why a need is unmet. Finally, the Board must have it understood—and remember the agreement—that the lost services will be reinstated at the earliest possible moment.

Anne R. Winslow, President,
Visiting Nurse Association, New Haven, Connecticut.

BOARD EDUCATION

The change which has lifted money raising responsibilities from the shoulders of many boards and has lessened the tasks at which board members work side by side with the staff, has been responsible for a great falling off in board interest. The fundamental truth that we must work in order to enjoy the great satisfaction that results from a vital interest was never more clearly seen than in this situation.

In educating board members, there are two problems, basically the same: Education of the new board member and re-education of the old. How shall we breed interest in a semi-passive group?

We are attacking this problem in Louisville with the belief that "interest" made painlessly digestible by the expert and handed out for consumption to the passive listener is practically valueless. Rather must there be an active, creative effort made by the individual. So, in Louisville, instead of a series of talks to the novice, a round table of new members is held and each is assigned a topic covering one phase of the work which she investigates by personal observation, reference reading, and information gathered from the staff. Each presents her topic in turn. The result is a group of new members with general information plus (and this I believe to be the important point) a specialized knowledge of *one* subject made vital by his or her personal creative effort to investigate and to present the topic vividly. (You may also find a burst of fresh ideas, constructive suggestions and personal help resulting from this individual study.) Such knowledge should be enough, even though the subject be a minor one, to make the cause peculiarly the new member's. We thus protect new members from that uncomfortable experience of sitting on a board and feeling that everyone understands but herself. We believe that this feeling of inferiority kills more potential energy than any other single factor.

The constant re-education of the board follows this same line of reasoning. A topic prepared for the regular meeting by a board member will focus the mind of one member on a problem of the work and on the need for board education. These topics, assigned in turn, will give each board meeting a personal and vital contact with the work which can not be achieved from a report prepared by a trained worker. If the work is active and progressive, at such a time as this there can be no lack of vital subjects to study!

Mrs. Macauley Smith, Chairman, Education Committee,
Public Health Nursing Association, Louisville, Ky.

TOPIC VI

USE OF THE RADIO

PREPARING FOR THE SPEECH

There are many things for an amateur radio speaker to keep in mind when he is preparing his talk and while he is making it.

What is the speaker's relationship to his listeners? He is going to be a guest in his listener's home. He must be courteous, interesting, clear and logical in his statements.

The audience is vast, unseen, heterogeneous. The speaker is robbed of all personal contact with his listeners. He cannot get the "feel" of his group and he is even robbed of the sound of his own voice as many broadcasting rooms are soundproof and sounds are deadened. He is quite likely to enter a family group where all ages are represented. Rich and poor, literate and illiterate, all types may be listening in. Every word must be descriptive and alive and the message interesting or a twist of the wrist removes the audience! The first few sentences are the most important, but it must be remembered that some of the audience will come in during the talk, so interest must be sustained throughout.

Mr. Morse Salesbury* gives a good formula for the organization of a radio talk:

1. A greeting to the audience.
2. An interest-getting opening.
3. A summary of the points the talk is going to cover.
4. A swift interesting development of the summary outline.
5. A final summary to clinch the point in the minds of the audience.
6. A direction to the listeners who may now be interested in getting further information on the subject.

GENERAL RULES TO KEEP IN MIND

Every radio speech should be written out in advance, clearly written on loose sheets or cards that will not rustle when turning pages.

The speech should be rehearsed and timed to the last minute. Time must be allowed for the introduction and closing remarks of the announcer. The speaker should be sufficiently familiar with the material to be able to present it in an informal manner.

Speak your paper softly, clearly, slowly. A conversational tone is much more interesting than an oratorical one. Avoid clearing the throat or coughing.

Keep the tongue as far as possible from the roof of the mouth to avoid hissing sibilants. Don't swallow your last syllables.

The voice is very important on the radio and tests may be made at the broadcasting station before selecting the speaker to give a talk.

The radio audience is the newsreading public, so tie up your talk to some current event.

The most effective radio program is one which derives a certain amount of support from the newspapers.

WHAT HOUR TO BROADCAST?

Dr. R. G. Leland in a paper on *Rating the Radio* gives a very interesting discussion of the best broadcasting hour:

"There is no formula by which the best broadcast hour or period can be determined for each community. It is probable that the health broadcast must of necessity be placed at a

*See reference reading

WHAT HOUR TO BROADCAST

(Continued)

period not already occupied. Radio stations are obligated by contract which call for specified periods. Attractive as some of these occupied periods may appear, the profession must respect the rights of prior contracts. The available radio listeners, who potentially constitute a radio health audience, automatically fall within certain classes which may be divided roughly according to the several periods of the day. The periods represent more or less faithfully our national customs. The first may be designated as the rising, bacon and egg, or daily dozen period. The most appropriate program for these hours consists of familiar, catchy, popular music interrupted now and then by the physical exercise experts who strive to create in you enthusiasm and pep for the day's work. That part of the radio audience that may be listening at this hour is likely to be more interested in the dreamy strains of soft piano music, or the witty side remarks of the physical director, than in some informative talk which would require more cerebration on its part.

"The next period may be called the plate polishing or household hustling period. Over at least a portion of this time the housewives are at home, the children are at school, and the wage earners are at their jobs. This is a very good time to talk to the women. Then follows the laborer's lunch period. I call it laborer's lunch since it appears that nowadays nearly everyone is laboring to shorten his lunch hour and disregard all the benefits that may come from congenial mealtime environment and deliberate enjoyment of food. This period offers a splendid opportunity to present a brief health talk to a large group.

"Next comes the bridge and matinee period. It may be easy or next to impossible to break into the deliberations of the groups that gather during these hours, depending on the indifference or seriousness with which they enter upon their social obligations.

"Finally, there is the period of social dinners, theaters, dances, and family fun, the period of radio extravaganzas representing an investment of millions on the part of commercial advertisers. It will be seen then that a forenoon period will reach mainly the housewives, shut-ins, and sick; the noon period will reach, for the most part, those who chance to eat within sound of a loud speaker; an afternoon hour will be largely for the benefit of women, while the evening period is sure to reach by far the largest group of both sexes and all ages, but one which shifts as the evening hours advance.

"Experience with health broadcasts extending over nearly eight years leads me to recommend the following choice of hours, providing, of course, they are available: For the morning, 10 o'clock, then the noon period; for the afternoon, 3 o'clock, and for the evening, 7:30. The choice of time will depend somewhat on the habits of the community and the trend of local broadcasting; it will be influenced also by local pickups from national chain health broadcasts."

TYPES OF BROADCASTS

Public health broadcasting may be divided into five types:

1. Simple announcements.

   These are especially adapted to slogans or money raising campaigns. Christmas seal campaigns, Red Cross drives, and Community Chests have used simple announcements to advantage. Some have developed a "radiogram" or "radiolog" giving in a few words some pertinent health fact or a news item of what the organization is doing.

2. Participation in other programs.

   Perhaps you heard the Maxwell House Show Boat Hour in which Cap'n Henry gave a message about the Red Cross? Dr. Haggard in his popular feature *Devils, Drugs and Doctors* has expounded the value of the Early Diagnosis Campaign of the National Tuberculosis Association. Many other commercial hours will be willing both on national hook-up and local commercial programs to allow reference to reputable, non-commercial public health movements.

3. Talks.

   It is best never to talk longer than fifteen minutes, in fact ten and even five minutes is better for this type of subject.

   The talk may be an occasional one or it may be a series coming on at a regular time each day or week.

TYPES OF BROADCASTS

(Continued)

In talking about public health nursing, avoid technical phrases and rare terms. If you have to use them, be certain to define them. Be personal and direct in your message, try to analyze and visualize the members of your audience and try to fit your talk to them.

Use true stories, disguising identities. Some organizations have had a client come to the microphone, thus obviating the usual objections to identifying clients and unwelcome publicity.

It is possible to arrange good musical programs, with the health message kept very brief.

Some agencies have had contests on radio speaking by high school students. A winner of a contest conducted by the Minnesota Public Health Association described a prize fight between the Germ Champion, Max T. B., and the People's Champion, Jack Health:

"Jack Health is down, folks, as a result of that last blow; The Referee is counting (1, 2, 3, 4, 5, 6, 7, 8). I'm so excited, I can hardly talk. He is up again and how! He lands a powerful right upper cut on the side of Max's head. Now another, then a left one! These blows are all results of the 1931 Christmas Seal Sale Campaign going over the top. Follow-up nurses to keep check on ex-sanatorium patients, tuberculin-testing and health examinations for school children, more clinics, additional health literature and health lectures all went into those last blows."

4. Radio Forums.

   Discussions by prominent people of the community about some of the local health problems and what is being done to improve them.

5. The Dramatic Sketch.

   This is a very effective means of holding a radio audience but one should study carefully the professional drama which is now being broadcasted. Visit a broadcasting station to see how it is done and listen to those sketches now going on.

   Keep the cast very small—three at the most.

   Be sure your cast is absolutely letter-perfect and keep the action simple so as not to confuse the audience. Remember that there can be practically no "stage business" not described by the actors or made plain by sound effects—slamming door, puffing train, etc.

Several State Departments of Health and City Health Departments have used dramatic episodes very effectively. The Detroit Dairy and Food Council and Detroit Department of Health have conducted a radio drama during the winter each Saturday night. The Racine Board of Health took the family on a vacation trip two years ago. The first episode was a visit by the mother to the Health Officer. We quote the first part of it here to show the opening of the sketch and the general tone of the broadcast:

"As the summer season wears on we begin to think about vacations. More and more of us are taking to the road each year, and our motor cars lead us far from the beaten path. Vacations are rightly regarded as necessary to good health and efficiency, but there are unfortunately some dangers involved in them, too. In order to get the full benefit of a vacation, it is necessary to give some thought to choice of the kind of vacation one is to take, and make some preparations to see that all goes off successfully and without results which may spoil the whole plan. Especially important is it to avoid coming home from a vacation and becoming ill thereafter with a contagious disease picked up enroute. The Racine Health Department is prepared to advise prospective vacationists about health during their holiday. Let us suppose, for instance, that you have done, as has the imaginary Mrs. Martin, who is just entering the Health Commissioner's office. Listen: [This was actual dialogue between two people.]

Doctor: Good morning, Mrs. Martin.

Mrs. M.: Good morning, Doctor. May I have a moment?

Doctor: Two, if you like.

Mrs. M.: I want to ask you some questions that may sound foolish to you.

Doctor: Very few questions sound foolish to me.

Mrs. M.: We are going for a vacation.

Doctor: Every one ought to, if possible.

Mrs. M.: So we decided, though my husband wasn't much in favor of it.

Doctor: Couldn't bear to let go of his daily work, I suppose?

Mrs. M.: Yes, that's just it. To hear him, you'd think that if he quit, the business couldn't go on.

Doctor: Of course, they do depend upon him. I know that.

Mrs. M.: Well, they can just stop depending on him for a couple of weeks. We haven't been away from home for a vacation in three years, and I'm determined to go this year. But that doesn't interest you, does it?

Doctor: In a general way, it does interest me to have people insist upon vacations. Not enough of them do it. They ought to. It improves their health and efficiency.

RADIO DIALOGUE

(Continued)

Mrs. M.: Well, anyway, I didn't really come in to tell you about the argument with my husband. I want some information.
Doctor: I hope we have it.
Mrs. M.: The newspaper said you had it.
Doctor: Quoting me, I suppose?
Mrs. M.: Yes.
Doctor: Good. At least someone reads what we give to the papers.
Mrs. M.: I think a lot of people do.
Doctor: I hope so. Now, what particular thing do you want to know?
Mrs. M.: We are discussing what kind of a vacation to choose.
Doctor: That's a pretty broad question . .etc. [The talk went on to discuss vacations from every standpoint of health and safety and further sketches actually took the family on a camping trip.]

We also quote the opening paragraphs from three other radio speeches which were given with success recently:

"THE NURSE IN PUBLIC HEALTH"*

"We are sure that there are many in the radio audience who recall the disastrous effects of epidemics in earlier days when health forces were not so well organized as they are today. For example, there were the flu epidemics of 1918 and 1919 when hospitals were filled to overflowing and emergency workers gave whatever care they could to sick families left in their homes.

"That experience brought to the popular attention the lack of an agency in Rochester to give nursing care to the sick in their homes. The Public Health Nursing Association of Rochester was then organized to fill this need. Its continued service has been made possible by the Rochester Community Chest.

"You are acquainted with the familiar figure of the Public Health Nurse as she goes about her duties dressed in her dark blue tailored uniform, carrying a black bag. Not only is she a graduate nurse, but she has had post-graduate training in public health nursing. The contributions of the Community Chest make it possible to give care to those in need. The Public Health Nurse goes where she is called, to any home in the city where health needs exist.

"One of their most interesting services is giving care to the mother and newborn child in their home, etc." [Case stories typical of each service followed.]

The following opening is from a radio speech presented by Jessamine S. Whitney, of the National Tuberculosis Association, over WEAF, 3:30 p.m., April 27, 1932:

"Why is tuberculosis among young women twice as prevalent as among young men? No one knows. It is one outstanding mystery of public health today—a worldwide phenomenon that threatens the happiness of the European, the South American, or the Australian mother and father just as much as it threatens American parents.

"In the face of a general decline in the tuberculosis death rate the group of young women between the ages of 15 and 24 continues to show the highest rate in the whole span of life for either sex. Many people have speculated on this in the press, from the pulpit, and through the air. Some ranted about short skirts and scanty clothing. Others issued a blast against dieting. Cigarette smoking also received adequate attention. A few laid it to the fact that the war opened the doors of industry to women. Even shampooing the hair in winter has been mentioned. And nearly all took occasion to point a finger at high school and college students and to raise an eyebrow at all extra-curricular activities, including late hours and whoopee in general. Which was right? None of them entirely. It was pure speculation.

"In an effort to obtain accurate facts which we hoped would help solve the mystery, the National Tuberculosis Association recently made a careful study, etc."

"WATCHING YOUR WEIGHT"**

"It is strange how few people are satisfied with their weight. The world seems full of fat people who long to become slender and graceful, and of thin people who dream of growing strong and stout and husky. In view of this fact, it is not so strange that the world is also

*Presented by Cora Warrant, Director of the Rochester (N. Y.) Public Health Nursing Association, over Station WHAM, 8:30 p.m. December 4 (Sunday), 1932. Miss Warrant was introduced by Dr. E. G. Whipple, chairman of the Public Health Committee of the County Medical Society.

**Presented by Dr. J. D. Dowling, Health Officer, Jefferson County Board of Health, over Station WAPI, October 5, 1932.

RADIO SKETCHES
(Continued)

full of self-styled experts, willing and anxious to assist the dissatisfied, either to gain or lose weight, but certainly to lose money.

"All this is very distressing. Changing one's weight is a serious matter, for, after all, etc."

LESSON ASSIGNMENT

Prepare a five-minute radio speech presenting the need for preventive health and nursing service at this time. Prepare a fifteen-minute radio sketch in dialogue describing a public health nurse's experience with one typical family or one typical case or one typical day. Give the speeches a trial "broadcast" before the staff or board. If successful, secure a real hook-up.

The N.O.P.H.N. will be glad to offer suggestions on this type of publicity, if you will send in your particular problems.

REFERENCES

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"Writing the Home Economics Radio Program"—Morse Salesbury. Reprint from *The Journal of Home economics*, November, 1932.
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See also article in this number of the magazine by Dr. W. W. Bauer, page 69.

MORE USE OF VOLUNTEERS

Reports from the Visiting Nurse Association of Springfield, Massachusetts, indicate that some very interesting work is being done there in the employment of volunteers in the various clinics operated by the organization.

Volunteers have had charge of the clerical work in nine child health clinics for some time, and last spring a plan was worked out for training lay workers to assist with the general clinic routine, including some of the educational work with the mothers. A fairly comprehensive course of eight lectures was given which included periods of observation of the routine in the clinics and in the out-patient department of a local hospital. The lectures covered the field of child welfare work, nutrition, growth and development of the normal infant and the normal preschool child, habit training of children and the keeping of records and use of literature. In addition to the clinic observation, reading assignments in relation to each subject were given and reports presented to the group by each individual.

Interest has also been worked up among ten Junior League girls to do volunteer work in a preschool dental clinic which is supported by the Junior League of Springfield. Two volunteers are responsible for each clinic and each girl serves for a two-month period. This group also was given a course of lectures covering the problems they would be likely to encounter in their clinic work.

Springfield is to be congratulated on its efficient use and training of lay people in a way which cannot fail to be beneficial both to the activities of the organization and to the workers themselves.

About 750 members attended the second annual meeting of the Massachusetts Organization for Public Health Nursing held recently in Boston.

Addresses were made by Dr. Richard M. Smith of the Harvard Medical School, Miss Sophie C. Nelson, Dr. George Bigelow, Massachusetts Commissioner of Public Health, and Dr. George A. Hastings, Extension Director of the White House Conference.

The afternoon session was given over to round tables, of which there were five, Mrs. C.-E. A. Winslow leading the Round Table for Board Members.

Mrs. Harold A. Marvin was elected president to succeed Miss Gertrude Peabody, retiring president of the organization.

SCHOOL  HEALTH

CHECKING SCHOOL NURSING ACTIVITIES

"If we are not studying our own methods we may be sure that some one else is," said Miss Chayer in her article, "Challenges to the School Nurse," apearing in the September PUBLIC HEALTH NURSING. In order to find out to what extent school nurses were attempting to measure the results of their programs and what methods and devices were being used to make their programs more effective, several school nursing services were asked to describe what they were doing in this regard. Among those replying were the Instructor in Health of the Brookline, Mass., School Department; the Berkeley, Cal., Department of Public Health; the Supervisor of Health, New Hampshire State Board of Education; the Monmouth County, N. J., Organization for Social Service; and the Millbrook, N. Y., Visiting Nurse Association.

The outline below is a summary of some of the devices mentioned, while all emphasized the value of results that were more or less intangible, such as attitude of teachers, children, and parents and better understanding between the community and the school. For simplification the material is grouped around the leading activities in the school nursing program.

I. *Periodic Health Examination*

A. One of the best methods for judging results is through the improved condition of the child and the correction of defects. Some of the devices used are as follows:

1. Individual health record for each child.

   To be kept in the school as a permanent and continuous record of child's health and development showing findings of examination and subsequent treatment and corrections.

2. Classroom summary or school health chart.

   a. For teacher's use showing number of defects and corrections. Not to be displayed. Children encouraged to report corrections to teacher.

   b. May be expanded to include teacher's observations of child's condition.

3. Classroom growth record.

   To promote interest of children in their own development.

4. Other devices.

   a. Dental certificate—signed by dentist every six months on completion of dental examination and treatment.

   b. Dentist reports periodically to nurse number of children attending him for dental care.

II. *Classroom Inspection*

A. General improvement in cleanliness of person and dress.

B. Fewer cases of skin conditions requiring exclusion.

C. Reduction in number of colds.

D. Lessened absence from preventable illness.

E. Increasing interest and participation by pupils.

III. *Home Visits*

While many results of this important activity are intangible, the following criteria may help:

A. The number of defects corrected.

B. Number of diphtheria immunizations both school and preschool.

C. Attendance at summer round-ups of preschool children.

D. Number of parents voluntarily seeking nurse's advice.

IV. *Health Teaching*

A. Periodic checking of "Habit Form" by pupils and teacher, to be used as a basis for study and future teaching.

V. *School Environment*

A. Periodic checking by teacher and nurse on such items as ventilation, lighting, washing and drinking facilities, toilets, playground, etc.

B. Number of schools serving hot lunches.

Other criteria* that have been suggested from time to time are:

A. Attendance of parents at health examinations.

B. Parents' visits to nurse in school.

C. Number of children entering school without defects.

D. Number of children taken to private physician for periodic examination.

E. Number of cases referred to school nurse by other agencies and number of contacts with other agencies.

F. Interest of the Parent-Teacher Association in the health program.

G. Increased appropriations for school health work.

How many school nurses throughout the country can conscientiously check each of the items in the foregoing outline knowing that they are making an attempt to render this service more effectively and in some measure to evaluate the results that they are getting? As one nurse who replied to our questions said, "I am afraid this is very inadequate, but at least it has shown me the need of more thought and study that I should be giving to this particular field."

*For additional criteria see "School Nursing" by M. E. Chayer, p. 239. G. P. Putnam's Sons.

A SUGGESTED FORM FOR REPORTING NURSE'S HOME VISIT TO TEACHER

Name of student..... Date of call.....
Referred to nurse by.....
Reason for call.....
Pertinent findings as result of call.....
.....
Other facts which have bearing.....
.....
Recommendations for further follow-up
By nurse .....
.....
By teacher.....
.....
Signature of nurse.....
Report sent to..... Date.....

"Not a health curriculum, but the actual making of a health curriculum by a group of teachers offers more possibilities as an integrating force than any other single activity," says Otto W. Haisley in his article, "Adjusting Health Education to the Newer Trends in Educational Philosophy" in the *Journal of Health and Physical Education* for October, 1932.

At a school clinic in Glasgow, a figure of 8 is drawn on the floor, and the children walk round its outline among the sunlight lamps. It is claimed that by this means every part of the body is exposed to the rays in equal proportion.

—*Maternity and Child Welfare* (England).

REVIEWS AND BOOK NOTES

Edited by DOROTHY J. CARTER

CHILDREN'S TONSILS IN OR OUT

A Critical Study of the End Results of Tonsillectomy. By Albert D. Kaiser, M.D. J. B. Lippincott Co., Philadelphia. Price $5.00.

Dr. Kaiser and his colleagues have presented a most important contribution to the much discussed problem as to whether and under what conditions tonsils should be removed. The circumstances are unusual.

During 1920-21 the citizens of Rochester, New York, concerned in community health, made it possible for more than 5,000 children designated by the examining physicians as suffering from diseased tonsils to have the benefit of surgical removal of tonsils and adenoids. At that time steps were taken to trace the progress of the children for ten years in order to collect data that might aid to a better understanding of the relations of tonsils and adenoids to health and disease in children. A similar group of children of corresponding ages, whose tonsils were not removed, were also repeatedly examined during this decade, and compared with the children of the operated group with respect to their development and the incidence of certain diseased conditions with which tonsils or adenoids have a part.

The results of the study, which has been conducted with great thoroughness and with the coöperation of the school authorities and many co-workers, are significant. Seventy-two per cent of the children operated on were mouth breathers. One year after operation only 9 per cent were suffering from this complaint. The results indicate clearly that the removal of the adenoids alone will greatly benefit children who have evidence of obstruction to nasal breathing and a tendency to catarrhal or suppurative otitis media.

Space only permits reference to some of the important conclusions that have been arrived at by the author. Throughout the book, however, there are extended references to the work of others in this field.

Dr. Kaiser's experience indicates that the removal of tonsils offers a 75 per cent chance of protection against repeated attacks of tonsilitis, while the natural decline in frequency of tonsilitis through normal growth is only 15 per cent in the same period. The enucleation of the tonsils, therefore, not only protects from many repeated throat infections but also from the more serious degenerative diseases which may follow attacks of tonsilitis. On the other hand, the removal of tonsils apparently has but slight effect upon controlling the incidence of the common cold. The removal of tonsils and adenoids to prevent cold should be undertaken if the tonsillar tissue is definitely diseased. The study does not demonstrate that the tonsils are often responsible for the occurrence of bronchitis and pneumonia. Cervical adenitis is decidedly reduced in tonsillectomized children over a ten-year period.

Carefully controlled cases indicate that the removal of tonsils and adenoids renders children less susceptible to both scarlet fever and diphtheria. The *first* attacks of rheumatic manifestations occur about 30 per cent less often in tonsillectomized children. The greatest reduction occurs in children in whom the tonsils have been removed at an early age. Recurrent attacks of rheumatism are not benefitted at all. The author points out that incomplete tonsillectomies do not offer equal protection.

The possible relationship of tonsils and adenoids to nephritis, malnutrition, asthma, hay fever, diabetes, mental development, and other conditions is discussed, although no general conclusion is reached. The effect of tonsillectomy in these instances must be considered

together with other factors affecting the individual child. The presence or absence of tonsils was not found to affect the incidence of pulmonary tuberculosis. In about half the cases tonsil infection is primary to tuberculous infection of the cervical glands and tonsillectomy aids in the recovery from this form of tuberculosis.

The work closes with a consideration of the various methods used in removing or treating diseased tonsils and of the complications which may ensue. Fortunately, these are rare in competent hands.

Based upon an unusually wide experience, Dr. Kaiser has prepared a conservative and thorough study of the relation of the tonsils to the incidence and course of various diseased conditions and the results systematically presented will be consulted generally by those who seek new and reliable information in this important field.

J. H. Mason Knox, Jr., M.D.

EMERGENCY WORK RELIEF

By Joana C. Colcord, Russell Sage Foundation, New York. Price $1.50.

Although heretofore the results of made-work programs have been on the whole disappointing, the unprecedented urgency of the past few years has driven many communities to embark on some kind of a work relief project. The material for this study was collected in 1931 from 26 communities which were conducting such a program under public or private auspices or a combination of both. Parts One and Two of the book comprise a description of the various plans employed, while Part Three, "Setting Up a Program of Work Relief"* embodies suggestions based on the common experiences in all the communities studied. The prevailing opinion seems to be that work relief should be considered an integral part of the total relief program of the community; and that, while it is an expensive form of relief, it can be invaluable when carefully administered in preserving the morale of selected groups of workers.

YOUR HEARING—HOW TO PRESERVE AND AID IT

By Wendell C. Phillips, M.D., and Hugh Grant, M.D. Appleton & Company, New York. Price $2.00.

This book presents a simple account for the layman of the mechanics of hearing and its care. The first part deals with the hearing apparatus and how it functions. There are several chapters on "ear troubles" and what may be done by the medical profession, as well as what can *not* be done. Various methods of testing hearing are discussed as to accuracy, ease of testing, etc. Re-education and rehabilitation for the deafened are dealt with sympathetically.

One of the authors of the book, Dr. Phillips, is founder of the American Federation of Organizations for the Hard of Hearing, and has done much toward educating the general public as to what may be done for the deafened or hard of hearing—as distinct from the totally deaf.

The whole book is a plea for better education in regard to hearing; for parents to take children to reputable otologists at the slightest suspicion of ear trouble; for the hard of hearing child to have instruction in lip-reading, as well as usual school instruction; for aid for the deafened adult to readjust his life to meet the new handicap; and for sympathy of the general public toward the estimated twenty million hard of hearing in the United States.

Miriam Kortright

THE BUSINESS MAN AND HIS HEALTH

By Jesse Feiring Williams, M.D. Whittlesey House, McGraw-Hill Book Company, New York. Price $2.00.

Pointing out that "the tired business man is a myth" and that the remedy for his attitude lies in his own ability to visualize his job, Dr. Williams presents in his book some sound advice for work and play, according to modern concepts of mental and physical health. The book is simply written and easily read—if business men will read it, and it is to be hoped they will.

*Published as a separate pamphlet, Russell Sage Foundation, December, 1931.

A NEW MAGAZINE FOR PARENTS

In a special effort to reach the parents of children in private schools the Parents' Publishing Association, which publishes the *Parents' Magazine*, has started *The Metropolitan Mothers' Guide*, a monthly periodical devoted to the welfare of children in New York and suburban private schools. The character of the articles and general set-up of the magazine are very similar to *Parents*. The December number includes "The Profession of Motherhood," "Dolls and Drums and Sugar-plums—a Classified List of Recommended Playthings," and "Holiday Health." The subscription price is $1.00 a year from the Parents' Publishing Association, 114 East 32d Street, New York.

How Do Physicians and Patients Like the Middle-Rate Plan for Hospital Care, a report of the second year's experience of the Baker Memorial Unit of the Massachusetts General Hospital, Boston, has recently been published by the Julius Rosenwald Fund, Chicago. The report shows that the majority of patients using this service have an income of $1,000-$3,000 and that the average bill for hospital care including medical service is approximately $300.

Municipal Housing by Helen L. Alfred gives a lucid description of the housing problem and suggestions for its solution through the municipal housing plan. Published by the League for Industrial Democracy, 112 East 19th Street, New York. 10 cents.

The Newspaper as a Social Agency is now available in reprint form from the Social Work Publicity Council, 130 East 22d Street, New York. 15 cents.

Physical Education and Health Education as a Part of All General Teacher-Training Curricula, Bulletin No. 10, 1932, by Marie M. Ready, can be obtained from the U. S. Office of Education, Washington, D. C. 10 cents.

Vision Testing for the Young Child, a report of a recent survey of this procedure throughout the country, by Mary Emma Smith and C. Edith Kerby, has been reprinted from the December *Sight-Saving Review*. The survey revealed that one out of every twenty-five preschool children in the country has a vision test as a part of the physical examination, and that vision testing of this age group has been started in 46 states. Obtained from the National Society for the Prevention of Blindness, 450 Seventh Avenue, New York. 10 cents.

Once again the *Annual Report of the Rockefeller Foundation for 1931* presents an impressive picture of the development of world health and scientific achievement. While there have been no great forward strides in the past year or two and no extensive new projects undertaken, nevertheless the ground that has been conquered is being held. During 1931 the Foundation assisted 47 countries throughout the world and 37 states in the United States in carrying on public health work, as well as contributing to the Health Organization of the League of Nations.

Good Teeth a Handbook for Teachers has recently been published by the Prophy-lac-tic Brush Company, Florence, Mass. The pamphlet contains fundamental information regarding the structure and care of the teeth and is simply but graphically illustrated. 10 cents.

Also helpful in teaching the importance of dental care is the "Survey of Dental Diagnosis," a chart showing the relation of all phases of hygiene to dental development throughout the child's growth from fetal life through adolescence. Obtained from the American Dental Association, 58 E. Washington Street, Chicago, Ill. Free.

"How the Private Physician Looks at Public Health Nursing," is discussed by Dr. A. M. Jeffrey in the *Canadian Nurse* for January.

NEWS NOTES

A generous gift from the Rockefeller Foundation has made possible an interesting project in nursing education at the University of Toronto. The plan includes the reorganization of the existing Department of Public Health Nursing and other graduate courses in institutional nursing into a School of Nursing in which both undergraduate and graduate courses will be offered. The content of the undergraduate course which will probably be three years in length, will be adjusted to provide a broad training fitting the nurse for either hospital or public health nursing, while the post-graduate courses will comprise more nearly true post-graduate work. The School will be financially independent and expects to have close affiliations with local hospitals and public health agencies for practical work.

✣

An extension course, "A Survey of Eye Conditions," is being offered by New York University in coöperation with the New York State Department of Social Welfare on Tuesdays, at 7 P.M., beginning February 7. The course is designed particularly for workers in the field, such as public health nurses, social workers, and sight conservation teachers. Classes will be held at the Medical College, 338 East 26th Street, New York City, and the fee is $20.00. Further information may be secured from the University Extension Division, 18 Washington Place, New York.

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The Michigan Board of Registration of Nurses will hold an examination March 9 and 10 for graduate nurses, March 9 for trained attendants, at the Olds Hotel, Lansing. All applications with fees must be on file in the office of the Board of Registration of Nurses, 314 United Building, Lansing, not later than February 21. Mrs. Ellen L. Stahlnecker, R.N., Secretary.

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The first meeting of the Advisory Board of the Divisions of Public Health and Child Welfare of the Department of Public Welfare of the General Federation of Women's Clubs was held in Washington in October. Mrs. Carl W. Illig, Jr., chairman of the Division of Public Health, led a discussion of the public health program. It was voted to appoint a sub-committee whose duty it would be to recommend a definite emergency program. The following were appointed: Dr. Louis I. Dublin, chairman; Miss Grace Abbott, Dr. John A. Ferrell, and Dr. Stanley H. Osborne. The new committee unanimously approved the Public Health Program of the General Federation, and voted to send the following emergency appeal to all State Chairmen of Public Health:

"The nation's womanhood must defend the nation's health. The women of America are once more called to mobilize—this time in the cause of national health defense.

"Throughout our land governmental economies are seriously threatening the foundation which we have labored these many years to build, and are seeking to tear down our health structures. If American stability is to survive, then the health of our people must be our *first* consideration. National, state, and local health budgets must not be slashed—our health standards must be maintained and improved against all odds. We must work for constructive, not destructive, economy."

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Dr. Kate Daum has been elected President of the American Dietetic Association and Miss Laura Comstock Chairman of the Community Education Section. Miss Comstock is a former contributor to this magazine.

✣

Examination of food handlers—of whom there are some 300,000 in the city of New York—will be carried on by

private physicians exclusively after January 1, according to the New York City Department of Health. The Sanitary Code requires all food handlers, such as cooks, waiters, soda fountain employees, butchers, bakers, and grocery clerks, to be examined in order to prevent the handling of food by those who suffer from communicable diseases.

Heretofore applicants were examined in the special clinics of the Health Department if they did not wish to go to private physicians. The conviction that the State should not compete with private physicians in the practice of medicine, together with the precarious economic position of so many private physicians, has led Health Commissioner Shirley W. Wynne to change the procedure. Dr. Wynne believes that "a person employed as a food handler should be able to pay the small fee, once a year, charged by a private physician for the required examination."

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"Five years' research has located 887 persons in the United States and 57 in Canada, who are both deaf and blind," reports the American Braille Press in its quarterly journal, . . . *And There Was Light*. "As a class, the deaf-blind in our midst are not only the most heavily handicapped and the most lonely of all human beings, but also, as a class, the most neglected," declares Mrs. Corinne R. Rouleau, who took part in the survey. "We even know of deaf-blind children who have been placed in asylums for the feeble-minded without proper trial—the so-called intelligence tests being quite worthless in evaluating their potentialities."

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A grant of $75,000 from the State Temporary Emergency Relief Administration to the Home and Work Relief Administration of New York City will make possible the provision until February 1 of some medical and nursing service to families on the rolls of the Home Relief Bureaus most in need of it.

Thirty thousand dollars of the $75,000 will be used directly for medical and nursing service and medical supplies for home relief cases. The remaining $45,000 will be used in three work projects for the employment of doctors and nurses. These projects are:

(1) Supplementing the regular staffs of the baby health stations of the Department of Health by about seventy nurses and ten doctors under direct supervision of the regular staff of the Department of Health.

(2) Caring for chronically sick patients discharged from Bellevue, Metropolitan and City Hospitals.

(3) Taking X-ray pictures of Porto Rican and Negro families under the care of the City Home Relief Bureaus in East Harlem. This will be done in an attempt to discover tuberculosis in its incipient stages. Follow-up and treatment, in clinics, will be provided for persons discovered to have tuberculosis. About 110 nurses and 20 doctors will be used for this work until February 1.

IMPORTANT NEWS

Something of personal interest to every reader of this magazine is going to happen during the week of April 3-8, 1933. We are going to smash a precedent—just like that! For the first time in our history, PUBLIC HEALTH NURSING is offering an attractive gift with every subscription received during the week of April 3-8. Not only that but an unusually generous subscription offer is being made at that time—namely: A fifteen months' subscription for the price of twelve, and just to make the celebration complete, to any one person or staff sending in ten subscriptions we will give one year's subscription free! Our motto this year is: Every nurse a magazine reader! This special offer will make it easy for you. This is the year that we come of age as a national magazine—hence Magazine Week. Further announcements regarding the week's celebration will be published in March.

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